2002

# Clinicians' incorporation of a sociopolitical analysis in the conceptualization and treatment of women's psychological distress.

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# CLINICIANS' INCORPORATION OF A SOCIOPOLITICAL ANALYSIS IN THE CONCEPTUALIZATION AND TREATMENT OF WOMEN'S PSYCHOLOGICAL DISTRESS

by

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A Dissertation
Submitted to the Faculty of Graduate Studies and Research
through Psychology
in Partial Fulfillment of the Requirements for
the Degree of Doctor of Philosophy at the
University of Windsor

Windsor, Ontario, Canada

2002

## ABSTRACT

Women's experience of psychological distress is influenced in part by unique economic, social, cultural, and political pressures associated with being female in a patriarchal society. Feminist researchers and clinicians have argued that clinical psychology has paid insufficient attention to the role of sociopolitical factors in women's distress, and claim that this oversight reinforces a patriarchal status quo that ultimately disempowers women. The present study investigated the range of ways in which a sample of 25 clinicians transformed psychotherapeutic practice in line with their perceptions of sociopolitical influences on women's distress. It also examined broad contextual factors influencing clinicians' incorporation of a sociopolitical model of women's distress in clinical work. In-depth, semi-structured interviews were conducted with therapists working within a range of theoretical orientations and occupational settings. Results were analyzed by transforming interview data into a hierarchy of themes using grounded theory techniques (Rennie, Philips, & Quartaro, 1988). Participants' appreciation of the sociopolitical underpinning of at least some of women's distress shaped their therapeutic approach in a broad range of ways. These ways pertained to the collection and evaluation of assessment data, the nature of the relationships created with clients, discussion of gender/power issues in-session, remediation of traditional gender role socialization, and the adaptation of traditional therapy techniques to help clients resolve intrapsychic conflicts associated with socialization in an androcentric world. Participants' concerns about the degree of emphasis on sociopolitical models indicated a tension between liberal humanistic values and a more critical feminist perspective. In many cases, liberal humanist rules of therapy constrained the integration of a sociopolitical analysis in clinical work. The risks and benefits of such a perspective is outlined, and therapeutic approaches which address both personal and political levels of analysis are outlined.

## ACKNOWLEDGMENTS

I would like to thank Drs. Jeanne Marecek, Rosemary Cassano, Stewart Page, Sandra Paivio, and Alan Sears for their support and constructive feedback at all stages of this project. I would also like to thank my friends, including the members of my research group and the cohort of friends I made upon entering graduate school with in 1994. You gave me many happy times at graduate school, and it has been a privilege to know and learn with you.

I would particularly like to thank some specific people, without whom I would never have been able to create this project. I would like to thank Dr. Charlene Senn for her unfailing dedication to and belief in her students. Dr. Senn's hard work, integrity, and commitment to research that improves women's lives has been a wonderful model to me and all of her other students. I would also like to thank Sheila Blair-Mosley for not only providing me with many practical supports but also being my cheerleader throughout the entire research process. I would also like to thank my research participants for sharing their experiences with me. Above all, I would like to thank my family, especially my parents, Ann and Ron Getty for their unfailing love, support, and encouragement.

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# INTRODUCTION

## Overview

The phrase "the personal is political", which emerged from grassroots feminism during the 1960s and 1970s, has been used by feminist psychologists to emphasize the relationship between women's disadvantaged status within society and their individual experiences of psychological distress. The notion that women's position in an androcentric society fundamentally shapes their psychology and plays a role in the development of psychological distress has been emphasized by several theorists (e.g., Miller, 1976; Tomes, 1992; Wenegrat, 1995). Empirical evidence also supports the idea that women's occupation of a subordinate social role plays a role in their distress (e.g., Klonoff, Landrine, & Campbell, 2000; Landrine & Klonoff, 1999; Landrine, Klonoff, Gibbs, Manning, et al., 1995). Despite this literature, mainstream clinical psychology has been criticized for overlooking the role of social factors in women's distress and overemphasizing personal, intrapsychic causes and solutions (Greenspan, 1993; Jack, 1991). It has been suggested that such a focus may ultimately blame the victim and perpetuate harmful power arrangements within society (Greenspan, 1993).

Over the past thirty years, feminist therapy has emerged as an alternative to mainstream clinical psychology's asocial focus. During this time, the feminist therapy literature has moved from providing critiques of mainstream practice to the development of therapies which attend to the social context of women's distress. Despite the proliferation of feminist literature, however, the paucity of descriptive studies of the ways in which a sociopolitical analysis of women's distress can concretely inform therapy suggests that more research is needed in this area. In addition, a small literature problematizing feminist therapy techniques, plus an overall appreciation of the

unavoidable personal and political repercussions to clients and society of therapists' values and models suggests that more in-depth analysis of the incorporation of sociopolitical models in clinical work is needed.

The present study attempted to capture a wide range of attitudes, beliefs, and practices described by a variety of clinicians regarding the incorporation of a sociopolitical analysis in the conceptualization and treatment of women's distress. This study was inspired by my own attempts, as a novice therapist and feminist, to explore ways of incorporating a sociopolitical model of women's distress in therapy. It was also inspired by my observation, based on several years of informal discussions with fellow students and with mental health professionals, that a wide range of attitudes, assumptions, and criticisms of a sociopolitical approach in therapy shaped the ways in which an appreciation of gender and power influenced clinical work. It was my hope that the presentation and explication of clinicians' practices and concerns could encourage debate about how therapy could best help women.

The remainder of this chapter consists of four main parts. First, I will explore the link between social factors and human distress generally, and women's psychological development and distress in particular. Second, I will then outline and evaluate the ways in which mainstream clinical theories have traditionally approached the issue of gender, power, and distress. Third, I will outline and evaluate alternative, feminist approaches to the conceptualization and treatment of women's distress. Fourth, and finally, I will present a rationale for studying psychologists' incorporation of a sociopolitical analysis of women's distress in clinical work.

# The Role of Sociopolitical Factors in Women's Distress

## *Society and Human Distress*

Since the beginning of large-scale, community mental health surveys in the 1960s, research has consistently shown that neither social power, defined as "the ability to provide for the needs and security of self and loved ones, to stand up for oneself in conflicts with others, and to make life decisions based on one's own desires" (Wenegrat, 1995, p.13), nor psychological problems such as anxiety or depression are equally distributed among all members of society. Mirowsky and Ross (1989), for example, argue that social structural variables associated with a lack of power and feelings of alienation, such as unemployment, poverty, and racial discrimination, lead to depression as a direct result of lesser access to resources, and indirectly through disadvantaged persons' expectations that future situations will be uncontrollable. The expectation of having no control leads to sadness, resignation, and difficulties identifying and acting on real opportunities to effect change. This condition has been termed "learned helplessness" (Seligman, 1975).

One important social variable associated with differing rates of power and thus, psychological distress is socioeconomic status. Epidemiological studies have consistently found that high socioeconomic status is associated with increased psychological well-being, while low status is associated with increased levels of psychological distress (Mirowsky & Ross, 1989). Higher levels of psychological distress amongst individuals from lower socioeconomic classes have been attributed to their experience of a greater number of undesirable life events (crime, poor housing, poor health, victimization, exploitation, etc.) in the context of fewer personal coping resources and social supports (education, employment, access to health care, etc.). Experiences of failure and victimization within this context are believed to result in increased feelings of alienation and

powerlessness, as well as cognitive and motivational deficits which create increased stress in a self-amplifying cycle (Mirowsky & Ross, 1989).

Prevailing ideologies that undergird our society have been held responsible for the differential distributions of material conditions which affect human distress. Attitudes supporting racial discrimination, for example, are thought to be partly responsible for variations in psychological distress within society (Mirowsky & Ross, 1989). In the United States, African Americans as a group are disproportionately disadvantaged (e.g., have lower levels of education and income) compared with their white peers. They also have higher levels of psychological distress. While their higher levels of psychological distress result in part from their lower socioeconomic standing compared to whites (Mirowsky & Ross, 1980), there is evidence to suggest that blacks living in poverty still have higher levels of distress than poor whites (Kessler & Neighbours, 1986). This has been attributed in part to the fact that racial discrimination has differentially interfered with the upward mobility of this group. In this context, perceptions of blocked opportunity are especially likely to make a person feel powerless, which leads to increased levels of psychological distress (Mirowsky & Ross, 1989).

Other theorists (e.g., Albee, 1982; Beit-Hallahmi, 1974; Cushman, 1995; Sipe, 1982) have argued that broader Western social ideologies such as capitalism play a role in the development of human distress. Excessive industrialization, and the dehumanization and objectification associated with it, for example, have been proposed to lead to "loss of individual creativity, of a sense of identity, and of personal competence..." (Albee, 1982, p. 25). Thus, the origins of psychological distress can often be found in the social, economic, political, and cultural structures which form the foundations of our society.

While such evidence does not demand that psychologists assume an exclusively social-reductionist view of psychiatric disturbance, it does highlight the importance of considering social factors in addition to factors within the individual when conceptualizing the etiology and treatment of psychological disorder (Twaddle, 1994). For the purpose of the present review, social factors can be defined as either "micro-" or "macrosocial" in nature (Prilleltensky, 1990). The term "microsocial" has been used to refer to the dynamics of the immediate social setting, for example, of the specific family or work environment of which one is a part. In contrast, "macrosocial" factors affecting distress refer to the broader, higher-level, often hidden overarching ideologies (e.g., capitalism, individualism, racism) that shape our society and institutions as a whole. Macrosocial variables subsume and influence both microsocial and individual worlds, and are in turn also shaped by them. It is these macrosocial influences that are the focus of this review and study.

### *Society and Women's Distress*

While social and political factors can be said to influence the mental health of all individuals, since the reemergence of the women's movement in the Western hemisphere in the 1960s, particular attention has been paid to the ways in which social factors shape the inner experience, behaviour, and mental health of women. One set of explanations for women's experience of psychological distress has centred on women's subordinate status and lesser power, relative to men, to define and attain their goals (Nolen-Hoeksema, 1990). According to feminist theorists, women's subordinate status in society reflects its inherently patriarchal nature. Patriarchy has been defined as:

> The manifestation and institutionalization of male dominance over women and children in the family and the extension of male dominance over women in society in general. It implies that men hold greater power in all the important institutions in society and that women are deprived of access to such power. It does not imply that women are either totally powerless or totally deprived of rights, influence, and resources, but certainly women as a group have less power, less influence, and fewer resources than men." (Lerner, 1986, p. 239).

Patriarchy is maintained by sexist practices, where sexism refers to the prejudicially negative evaluation of a woman based upon her gender (Reiker & Jankowski, 1995). Sexism has institutional, cultural, interpersonal, and personal/emotional dimensions, and can be manifested in a wide range of ways ranging from subtle, nonverbal cues in interpersonal interaction to violence against women, to institutional values and practices which devalue women and maintain gender inequality (Rieker & Jankowski, 1995).

Proponents of socially-based theories of women's psychological distress argue that patriarchy is a powerful explanation for some of the psychological distress experienced by women. Theories stemming from this theme have been termed "social role theories" of women's distress, as they highlight the cost of roles prevalent amongst women (Nolen-Hoeksema, 1990). Social role theories of depression focus on the ways in which different social roles are sanctioned for men and women and the effects of traditionally feminine gender roles on women's mental health. A social role consists of a set of qualities and activities that society holds to be appropriate for members of a group (Nolen-Hoeksema, 1990). According to the social-role theories, women's social status and lesser power in society partly contributes to their vulnerability to depression and other forms of psychological distress.

Taking a historical perspective on women's experience of mental illness, Tomes (1992) has argued that women's psychological distress and the forms in which it has been expressed have frequently been the result of rigid gender role prescriptions that women be more passive and

dependent relative to men. According to Tomes, women's discontent with gender role restrictions was historically expressed through "symptoms" of hysteria, which were interpreted by the newly prominent medical establishment and women themselves as an illness or disorder (Tomes, 1992). Based upon her analysis of archival records from the nineteenth century, a time in which hysteria and other psychosomatic disorders were prominent, Tomes (1992, p. 151) has argued that women's mental illness functioned metaphorically as a "desperate communication of the powerless" and a means of escape from the pressures of restrictive gender roles. According to Tomes, "...the historical record supports the argument that sex-role socialization may have predisposed men and women to gender specific reasons for and modes of expressing psychological distress" (Tomes, 1992, 151-152).

Tomes (1992) has argued that despite outward changes to the specific content of women's social roles, the subordinate position of women within society has remained the same. Accordingly, in contemporary times, some theorists have continued to assert that women's psychological distress can be linked to their position in society (Rieker & Jankowski, 1995; Nolen-Hoeksema, 1990). For example, Wenegrat (1995) has used theories of evolution and sociobiology to argue that disorders affecting a disproportionate number of women, such as depression, anxiety, and other, more contemporary disorders such as anorexia, somatization disorders, and multiple personality disorder are often "illness roles" assumed by the less powerful and reified by a society that is strengthened by their existence. According to Wenegrat (1995), these roles allow women, who have often been discouraged and prevented from accessing and using power directly, to meet their needs for power and status in indirect ways. Thus, depression may be an indirect way of rebelling against and opting out of noxious roles, gaining attention, support, or meeting other needs for self or dependents.

Contemporary social role theories can generally be grouped into two categories (see Nolen-Hoeksema, 1990). The first category highlights the emotional effects of women's experiences of covert and overt discrimination and victimization (Nolen-Hoeksema, 1990). These theories assert that these experiences, which include discrimination and devaluation at home and work, as well as violence against women, lead women to feel helpless, traumatized, and inferior. The second category of theories examines the mental health ramifications of caretaking, both as a primary role, and in interaction with other roles and demands (Nolen-Hoeksema, 1990). One theory within this second group has been called "the noxious nature of the housewife role" theory (Repetti & Crosby, 1984), and asserts that because the homemaker role is currently not highly valued and can be isolating, it can render women vulnerable to depression. Another theory, the "paucity of roles" theory (Repetti & Crosby, 1984) holds that when women assume a full-time homemaking role, the fewer sources of gratification associated with one versus multiple (e.g., career and family) roles may lead to depression, particularly when the primary role is disrupted or threatened. Still other theories within this second category, the "role strain and role conflict" theories (e.g., Gove & Tudor, 1973), hold that the conflicting demands of childcare, housework, and paid work may result in a uniquely stressful set of circumstances that lead women to distress and depression (For an overview of the above theories, see Nolen-Hoeksema, 1990). The following sections review evidence supporting social role theories of women's distress.

## *Inequality, Discrimination, Victimization, and Women's Distress*

### *Discrimination at Work*

Institutionalized discrimination against women in the world of work is evident in traditional definitions of work, women's historical access to employment, segregation of women into lower

paying, less prestigious jobs, biased evaluations of women's work, and the existence of sexual harassment. First, some authors have argued that work tends to be defined according to the traditionally male norm of paid employment. This has rendered much of the important work that women do, such as home and childcare, invisible and unappreciated (Unger & Crawford, 1996). Second, women and men have often had different experiences within the world of work (Unger & Crawford, 1996). Until approximately three decades ago, for example, overt and often legal discrimination prevented women from matching men's accomplishments in education and the workplace (Ehrenreich & English, 1978, cited in Nolen-Hoeksema, 1990). According to Basow (1986), it has only been within the past few decades that opportunities for women to attain high levels of education and find high-status, high-paying jobs have increased dramatically. At the same time, however, many women's upward mobility at work has been hampered by the "glass ceiling" effect, a term used to describe an inability to be promoted to occupational positions within seemingly attainable sight (Lorber, 1993).

In addition to discrimination based on the definition of and access to work, women's subordinate status is also reflected in gender segregation within the work place (Basow, 1986). The great majority of women work in "pink collar" jobs reflecting their socialization to engage in caretaking and service-related activities. Such jobs include secretarial work, waitressing, childcare, and retail sales. In contrast, men's jobs tend to emphasize leadership and authority. According to Basow, over 80 percent of skilled labourers, and 65 percent of managers and administrators are men. Problems with gender segregation in work relate to the fact that jobs traditionally held by women tend to be lower in prestige and pay than are those traditionally occupied by men. For example, according to Statistics Canada (1991), while 75% of workers in the 10 lowest paying occupations are women, 80% of workers in the highest paying occupations

are men. In 1991, the average annual wage of Canadian women working full-time was $26,842, compared to an average of $38,567 for men (Statistics Canada, 1993). In 1990, women's earnings were only 60.3% that of men's, despite over a decade of wage increases and increases in educational attainment amongst women (Rashid, 1993, cited in Statistics Canada, 1991). In addition, the notion that caretaking and women's work is devalued within society is strongly supported by findings that the lowest average employment income in 1990 was for child care occupations at $13,518 (Statistics Canada, 1991). This devaluation of caretaking roles often held by women compelled one critic to ask: "How much do we care about caring? And are we willing, as a society, to offer respect and a living wage to those who do it for us?" (Collins, 1988, cited in Statistics Canada, 1991).

The observation that women earn less than men holds true for women working part time and full time, for women from a range of ethnic backgrounds, and for the past forty years (Betz & Fitzgerald, 1987; England & McCreary, 1987; Kim, 1986; Nieva & Gutek, 1981; Russo & Denmark, 1984; U.S. National Committee on Pay Equity, 1994). While a number of studies have not found a relationship between women's lower pay and increased depression, when combined with women's greater responsibility for child care, increasing divorce rates, and difficulties receiving child support, women's lesser earning power often leads to vulnerability to poverty and distress amongst women. This pattern has been called "the feminization of poverty" (Goldberg, 1990; Goldberg & Kremen, 1990), and is supported by findings that the average income for families headed by a single mother was $26,500, while that of single fathers was $40,792 (Statistics Canada, 1991). The extent of this problem is reflected in findings that there were 788,400 families were headed by mothers and only 165,245 families headed by fathers in Canada in 1990 (Statistics Canada, 1991). As noted earlier, poverty has consistently been related to

depression (Mirowsky & Ross, 1989), so that we can expect that a substantial proportion of these women to be depressed (Nolen-Hoeksema, 1990). The situation is further complicated by the burnout and low rate of return associated with some pink-collar jobs. Baruch and colleagues summed this view up: "For women, it's not having a job that is bad for your health, it's having a lousy job with inadequate support for at-home responsibilities." (1983, p.180, cited in Nolen-Hoeksema, 1990).

Even amongst women who achieve academically and find a job, subtle gender bias exists which may prove even harder to fight than blatant discrimination. These biases include negative evaluations of women's work and negative attributions for women's success. A number of studies, for example, have found that the qualifications, performances, and opinions of women are given less attention and evaluated more negatively than those of men, even when these are identical (Basow, 1986; Feather & Simon, 1975; Johnson, 1976; Traynor & Deaux, 1973; Wallston & O'Leary, 1981). Not all studies have found these biases, however (e.g., Basow, 1986), and it appears that some biases are more likely when criteria for evaluation are relatively subjective and ambiguous. Unfortunately, however, promotion to higher status jobs tends to be based upon such subjective and ambiguous criteria (Feldman-Summers & Kiesler, 1974; Nolen-Hoeksema, 1990). Such biases may affect the rewards women receive, and may potentially result in lowered self-esteem and motivation that actually leads to diminished job performance (Nolen-Hoeksema, 1990).

Sexual harassment, which refers to "any deliberate or repeated sexual behaviour that is unwelcome and unwanted by the target" (Fitzgerald, 1993), is experienced by approximately fifty percent of women at some point during their academic or working lives (Fitzgerald, 1993). The experience of harassment is frequently described as degrading and embarrassing and can lower

self-esteem, foster feelings of self-blame, impair social and sexual relationships, create anxiety and depression, and lead to overall reduced life satisfaction (Fitzgerald, 1993; Gruber & Bjorn, 1982; Maypole, 1986). Some researchers have framed sexual harassment as an issue of power and social control, which reflects the low status of women (Fitzgerald, 1993).

In sum, discrimination against women in the workplace is evident in the definition of work, gender segregation into lower paying jobs, and sexual harassment. All of these manifestations may have negative impacts on women's mental health.

*Women's Power in Marriage*

Institutionalized sexism has also been argued to exist within the family. Traditionally, men have been expected to be the head of the household, and have had greater decision-making power than women. Bernard (1972) notes that this leadership role has traditionally been reinforced by laws which secured for men the authority to make decisions about finances, children's education, housing, divorce, and when sexual relations would take place within marriage. While many changes have occurred to equalize power in heterosexual relationships, the degree to which power relations still reflect this traditional model, and the mental health repercussions for women, have been studied by numerous researchers.

In general, there is some evidence for the persistence of a traditional power balance (Mirowsky & Ross, 1989). For example, while most marriages are characterized by compromise, men often continue to have greater decision making power regarding important issues such as finances (e.g., Blood & Wolfe, 1960; Peplau, 1983; Peplau & Gordon, 1985; Steil, 1994; Turk & Bell, 1972), and have greater importance attached to their careers relative to wives' (Gutek, 1989). For example, within two-parent families, 11 percent of mothers, but only two percent of fathers, took

days off work for family reasons (Graham, 1993). Similarly, a 1989 study of members of the American Psychological Association found that 42 percent of men, but only 19% of women have relocated for an increase in salary. In contrast, however, only seven percent of men but a full 25 percent of women had relocated to further their spouse's career (Gutek, 1989). While some theorists attributed this state of affairs to the pattern of exchange for men's typically greater educational and occupational standing relative to wives, this pattern persists even when women make more money than husbands. This suggests that cultural norms that demand that men be leaders within marriage are very strong (Steil, 1994).

Some authors have attempted to calculate the mental health costs to women of power differences within marriage. Some studies suggest that men may benefit more from marriage (Bernard, 1972; Fowers, 1991), a hypothesis supported by findings that married women have higher rates of distress than married men, while single women are less distressed than their male counterparts (Gove, 1972, Steil & Turetsky, 1987). Some researchers have attributed this pattern to perceptions of gender-based inequality, particularly around issues of childrearing and housework that often exist (Aida & Falbo, 1991; Finkel & Hanson, 1992; Steil, 1994; Vanfossen, 1981). A number of studies have found that perceptions of inequality are related to greater distress among wives. Such research is described in greater detail below.

*Violence Against Women*

Violence against women has been defined as:

> "...any act of gender-based violence that results in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty."

(United Nations, 1993, cited in The Final Report of the Canadian Panel on Violence Against Women, 1993, p.5). Many experts have argued that violence against women is an issue of power:

> ...[violence against women is] a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and which have prevented women's full advancement. Violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared to men. (United Nations, 1993, cited in Canadian Panel on Violence Against Women, 1993, p. 6)

One particularly harmful form of violence against women is sexual assault, defined as instances in which "one person engages in sexual behaviour against another's will" (Unger & Crawford, 1996, p. 532). Sexual assault encompasses acts which can range from unwanted sexual contact, such as forced touching, to attempted rape and rape. In a 1993 report, the Canadian Panel on Violence Against Women estimated that approximately two out of three adult women in Canada have experienced what is legally recognized to be sexual assault. Of these assaults, 40 percent met the criteria for rape, and 31 percent, attempted rape. Over eighty percent of sexual assaults had been perpetrated by someone known to the victim. Clearly, sexual assault is a large problem facing our society.

The psychological costs of rape are significant, with many victims experiencing persistent fear and anxiety, phobias, depression, diminished self-esteem, sexual dysfunctions, alcohol and drug use, interpersonal problems, and stress-related physical ailments (Burnam et al., 1988; Canadian Panel on Violence Against Women, 1993; Unger & Crawford, 1996). Some researchers have argued that a significant proportion (e.g., 25%) of rape victims experience symptoms severe enough to meet a formal diagnosis of post-traumatic stress disorder (Hoecker & White, 1996, cited in Unger & Crawford, 1996), while others estimate that approximately 31 to 48 percent of victims seek professional assistance for dealing with the trauma (Koss & Burkhart, 1989). The

psychological effects of rape are also reflected by findings that rates of sexual victimization are much higher within clinical samples compared with the general public (Carmen, Rieker, & Mills, 1984; Jacobsen & Richardson, 1987).

Research has discovered that recovery from the trauma of rape is generally not rapid. While some studies have found that levels of distress return to normal within six months (Kilpatrick, Veronen, & Resick, 1979; Wirtz & Harrell, 1987), others found that depression and anxiety persist. Kilpatrick and colleagues (1981), for example, found that only 20 to 25 percent of victims were free of depressive symptoms one year following their assault, while Koss and Burkhart (1989) found that 26 percent of respondents still did not feel fully recovered four to six years afterward. Clearly, then, the sexual assault of women, often linked to the cultural devaluation of women, has long-lasting and seriously negative emotional effects.

Spouse abuse has been defined as the use of physical force or psychological abuse by one partner in an intimate relationship against the other (Unger & Crawford, 1996), and most frequently occurs within heterosexual couples where the woman is at greater risk of physical harm (Straus, 1993). Some have argued that women's subordinate status relative to men has traditionally led to a certain social tolerance toward the physical control of wives (Browne, 1993). In addition, women's lesser earning power and limited help for childcare often make leaving an abusive marriage more difficult .

U. S. research suggests that women have a 33 percent chance of being battered at least once in their lifetimes (Straus & Gelles, 1990). The Canadian Panel on Violence Against Women (1993) found that approximately 27 percent of women have experienced a physical assault in an intimate relationship. In 36 percent of these cases, women reported fearing that they would be killed by their male partner (in all cases the perpetrator was a male partner), and 25 percent had

been threatened with death. Clearly, physical violence against women in intimate relationships also represents a serious social problem.

The psychological effects of physical violence in intimate relationships have been documented extensively. As a result of the trauma of abuse, some women develop symptoms of post traumatic stress disorder (Koss, 1988) or a special subtype of this disorder, which has been termed battered women's syndrome (Walker, 1993). It is also common for women to internalize negative images of themselves that have been promoted by the abusive spouse, and to experience intense feelings of helplessness (Walker, 1979; 1984). Feelings of depression are also common. Rounsaville (1978), for example, found that 80% of a sample of battered women had significant depression and 53% met all criteria for a diagnosis of major depressive disorder. In addition, estimates of the rate of suicide attempts in battered women range from 25% (Stark, Flitcraft, & Frazier, 1979) to 42% (Gayford, 1975). Such research suggests that wife abuse leads to significant mental health problems for women.

The above research indicates that many women are victims of violence and that many suffer serious psychological damage following their victimization. While violence against women is not the only cause of distress for women in society today, it is one important source of harm for women (Nolen-Hoeksema, 1990).

### *The Noxious Role of the Housewife/Paucity of Roles Theories*

While the role of homemaker has been idealized in certain ways within society, the emotional costs of this role have long been described by authors, such as Charlotte Perkins Gilman (1973), Betty Friedan (1963), Adrienne Rich (1976), and others (e.g., Luxton, 1990). In order to explain findings of women's higher levels of depression relative to men (Nolen-Hoeksema, 1990), some

researchers have investigated whether, in addition to the idealized and real rewards of the homemaker role, this role has noxious elements which have detrimental effects on the mental health of women. In addition, other researchers have pointed to the fewer options for reinforcement inherent in the traditional homemaker role compared with the multiple rewards and protective effects of engaging in both paid work and family (see Nolen-Hoeksema, 1990).

Some research findings concur with the notion that, while rewarding in many ways, traditionally feminine roles have negative aspects that increase women's distress. The contemporary homemaker role has been characterized as difficult and time-consuming, but also invisible, low in prestige, and economically unrewarding (Vanek, 1984; Unger & Crawford, 1996). Particularly if childcare is involved, homemakers may be isolated from other adults but have little privacy and free time (Gove & Geerken, 1977b). As might be expected, parents, and particularly mothers, have been found to report greater psychological distress than nonparents (Gove & Geerkin, 1977; Pearlin, 1975), and homemakers have been found to report greater depression and dissatisfaction with home life than all other occupational or family status groups (Crosby, 1982).

Homemakers' complaints of depression have been found to be highly related to feelings of being unsupported by their spouses. While children are an economic burden on both parents, they are more likely to place greater emotional and physical demands on mothers, who are most likely to be at home with them (Nolen-Hoeksema, 1990). Some studies have shown that many women expect their partners to assume an equitable role with childcare, and that the violation of these expectations after a child's birth is associated with marital discontent and depression (Brown & Harris, 1978; Ruble, Fleming, Hackel, & Stangor, 1988). Other studies have suggested that homemakers with access to greater financial resources reported lower levels of depression than

those who had lesser financial resources. One reason for this correlation might be that homemakers who are more well-off can afford to pay for help with housework and childcare, and could therefore choose to engage in a wider range of activities (Repetti & Crosby, 1984). In addition, studies of men who lack multiple sources of reward (e.g. the never-married or widowed) reveal greater levels of depression than married men, who may be seen as having multiple work and family roles (Aneshensel, Frerichs & Clark, 1981; Crosby, 1982; Radloff, 1975). Thus, not having a variety of roles to provide reinforcement may lead to greater vulnerability to depression, particularly if one of the few sources of support are threatened or lost.

### *Role Conflict/Overload Theories*

While the noxious role of housewife and paucity of roles theories explain the frequently buffering effect of multiple roles on women's psychological well-being, role overload theory (Gove & Tudor, 1973) may help explain why some epidemiological studies have found that housewives are not more depressed than married, employed women (Aneshensel, Frerichs, & Clark, 1981; Radloff, 1975; Roberts & O'Keefe, 1981). This theory proposes that despite the progress inherent in women's movement into the paid work force, societal expectations that women will assume primary responsibility for child and house care means that they have, in effect, two jobs. For many women, the result of this dual role is feelings of conflict, overload and in some cases, depression.

The notion that women who work and have children have two full-time jobs, is supported by research findings that although gender roles are changing, women still assume primary responsibility for housework and childcare (Baber & Allen, 1992; Blair & Lichter, 1991; Crosby, 1982; Ferree, 1987; Luxton, 1990; Mirowsky & Ross, 1989; Zappert & Stansbury, 1984). For

example, a recent Canadian study found that on average, women who work outside the home spend an average of 3.2 hours per day on domestic work, child care, and shopping, compared to 1.8 hours for men (Graham, 1993). In addition, four times more women than men reported that four out of five domestic responsibilities were mostly theirs. Men reported that they had primary responsibility only for yard work and "cleaning outside the home" (Canada Health Monitor, 1992, p.6). In general, the pattern seems to be one of "overworked women and resistant to moderately involved men" (Unger & Crawford, 1996), a pattern which is found across ethnic and cultural lines (Hoschchild, 1989; Hossain & Roopmarine, 1993; Sanchez, 1993).

Research also suggests, however, that the depression associated with dual or multiple roles is not automatic, but rather depends upon the level of assistance a woman receives from her partner, difficulties finding childcare, and the nature of the paid work a woman does. Vanfossen (1981) and Repetti (1990), for example, found that working women in more equitable marriages, in which husbands willingly shared housework, were significantly less depressed than women in marriages characterized by less sharing of housework and greater conflict over the division of labour. While these studies examined only women, Hughes and Galinsky (1994) compared the effects of job and family conditions and work-family interference on psychological symptoms among both men and women. Results showed that women in dual-earner families reported more distress than men in either single- or dual-earner families, reported greater work-family interference, more household labour inequality, and more childcare difficulties than men. When these variables were controlled, gender differences in levels of distress were attenuated, providing support for role conflict/overload theories.

Mirowsky and Ross (1989) also found that levels of depression amongst married, working mothers, varied according to the degree to which husbands shared childcare responsibilities, and

ease of arranging childcare. Mothers' levels of depression were lower if husbands shared child care, and child care was easily available, whereas lack of support from husbands and difficulty arranging childcare was associated with greater depression. According to these authors, employment, motherhood, and easily arranged and shared childcare seem to be associated with the lowest levels of depression, while employment and no children was associated with the second lowest levels of depression. The third best arrangement for women seemed to be employment, and assistance from the husband in the face of difficult child care arrangements, while the most detrimental setting seemed to be being employed, having young children, having difficulty arranging childcare, and having sole responsibility for childcare.

The nature of a woman's job may also impact whether dual roles of work and home are beneficial or stressful (McBride, 1988). For example, women working as caregivers in schools, nursing homes, hospitals, or elsewhere may not gain as much benefit from this role because the duties are much like the duties required at home. In contrast, stress may also result from conflicting expectations inherent in the mother and worker role, such as requirements to be nurturant or competitive, and a full-time mother versus a committed employee (Unger & Crawford, 1996).

### *Intrapsychic Effects of Patriarchy*

The preceding sections have presented empirical evidence correlating social roles characteristic of women with levels of psychological distress. In addition to this type of work, many clinician/theorists have attempted to examine in greater detail women's psychological development within patriarchal culture (Jack, 1991; Miller, 1986). According to these authors, women's socialization into subordinate roles relative to men shapes important aspects of women's

personalities, and in some ways, may make them particularly vulnerable to certain mental disorders. While many theorists have sought to develop a new psychology of women that takes into account the often sexist context of women's lives, the work of Jean Baker Miller (1986) is perhaps best-known. Her contributions to the understanding of social forces on women's psychology are discussed below.

*Jean Baker Miller: Toward A New Psychology of Women*

The ongoing work of theorists at the Stone Center at Wellesley College, and in particular, Jean Baker Miller's landmark work, Toward a New Psychology of Women (1986) provides a comprehensive view of the ways in which patriarchy shapes and often limits women's psychological development. According to Miller, psychological characteristics particularly emphasized in the socialization of women, such as an orientation toward monitoring and caring for the needs of others and a greater connection with personal feelings of helplessness and vulnerability, ultimately reflect women's training as a subordinate group relative to men, and can often lead to psychological distress. In addition, Miller argues that women tend to be assigned those attributes that are devalued and disavowed by the dominant male culture. In this way, women are the "carriers" for certain aspects of the total human experience that remain psychologically problematic and unresolved. As a result of these larger power dynamics, Miller argues that women's psychological development proceeds from a different basis from that of men. According to Miller, different organizing principles structure women's psyches, such that traditional Freudian concepts of "ego" and ego development do not apply and are androcentric. Instead, she suggests that a central element in female psychology is the role of caretaker and supporter. Based on this, women are thought to develop a sense of identity based on an

appreciation of the "self-in-relation" to significant others, instead of an autonomous, self-contained self thought to be more characteristic of male socialization. According to this view, caring for others is not just a part of the backdrop of women's lives, but a major organizing and driving force within the female psyche (Miller, 1986, p. 63).

According to Miller, psychological costs are inevitably incurred when women are judged by their success in conforming to a traditional feminine role that is largely devalued by society. Caring for and serving others, for example, is generally seen as a "loser's" job (Miller, 1976), yet women are expected to do it, are judged by their capacity to do it, but are ultimately also devalued as a group for it. According to Miller, problems first arise when the psychological qualities socialized to be more prevalent amongst women are devalued and seen as liabilities instead of strengths which can lead to growth and change. Depression may result when women absorb untruths about women's worth and qualities that have been created by the dominant group. Problems also arise when the social bases for attributes more prevalent amongst women are obscured, such as, for example, when women are criticized as too passive, dependent, or masochistic. In each of these instances, there is little recognition of the ways in which social forces produce these qualities, frame them in a negative light, and often stand in the way of the expression of alternative behaviours. Our society has traditionally acknowledged and prized what men do more readily than for women, and has often discouraged women from showing anger openly or undertaking a too direct and open pursuit of their own goals (Lerner, 1988; Caplan, 1984). The backlash against women's pursuit of careers and other aspects of greater independence described by Faludi (1991) may be one example of this social attitude. As a result of these social forces, women may often have greater difficulty than men admitting strengths and allowing themselves to use their own resources.

According to Miller (1986), psychological distress also results when women are encouraged to occupy a caretaking role on a too exclusive basis. Miller describes at length the distress that arises when adherence to prescribed caretaking roles leads women to feel that their lives are not actually their own. As a result of society's promotion of the caretaking role for women, and women's resulting identification with that role, Miller argues, women have often had difficulty identifying needs of their own. Instead, she says, they learn to divert their own needs and transform them, not recognizing them as their own but rather seeing them as identical to the needs of others, particularly those of men or children. The expectation that one's own needs will and should be fulfilled through giving to others, however, may ultimately lead to feelings of resentment and depression, which are puzzling and threatening due the lack of a framework through which to understand and allow them. According to Miller, the fact that women are frequently expected to help others' development without the equal opportunity to growth for themselves is a form of oppression. Miller argues that when this oppression is identified, when women refuse to act as carriers of unresolved psychological issues, and when men and women are both encouraged to integrate a wider repertoire of roles and behaviours, a profound change toward equality can occur.

## Clinical Psychology's Treatment of the Social Factors Affecting Women's Mental Health

While not a comprehensive overview of the writings on the social bases of women's distress, the literature outlined above suggests that the economic, political and cultural environment in which women live, and which devalues and disadvantages them relative to men, is implicated in the development of women's distress. Congruent with this view, the feminist view that "the

personal is political" has been interpreted by feminist psychologists to mean that women's distress is related not only to idiosyncratic, intrapsychic factors, but also to institutionalized limits upon women's power (Hanisch, 1971). While a strict social causation model is not promoted here, if it is indeed the case that women's distress is partly derived from a social context in which they are devalued and disadvantaged relative to men, it follows that clinical psychology should attend to these factors in the development of clinical theory, practice with female clients, and the training of students. Hill and Ballou (1998) have argued specifically that clinical psychologists must look at how the social context affects women's mental health in every therapeutic situation, must value women's experience and critique psychological concepts, including that of mental health and illness, for androcentric bias, pay attention to gender-related power dynamics in the microcosm of the therapy hour, and consider social change as an ultimate goal of psychology and therapy. While these suggestions may make some sense, there is evidence both for and against the idea that psychology adequately addresses the social context of individuals' distress. It is to these issues that I now turn.

### *Clinical Psychology's Inattention to the Sociopolitical Context of Women's Distress*

A review of the literature on clinical psychology's treatment of social factors in human distress suggests that while many important efforts have been made to promote a socially aware and socially responsible psychology, the field has largely emphasized individual intrapsychic, and microsocial, individual family dynamics in the conceptualization of human distress (Prilleltensky, 1994). Accordingly, several feminist thinkers and clinicians have criticized clinical psychology for neglecting the role of sociopolitical factors in women's distress (e.g., Shields, 1975; Ussher, 1991; Weisstein, 1968).

Psychology's lack of attention to the influence of social forces on men's and women's behaviour was evident as early as the late nineteenth and early twentieth centuries. Stephanie Shields (1975), for example, has argued that despite psychology's longstanding claims to be value-free and scientific, psychology has long played "handmaiden to social values" that position women as inferior to men (pp. 753). Exploring the early functionalist, Darwinian, and psychoanalytic schools of psychology, Shields found an exhaustive list of "objective" psychological theories that reified social myths to explain women's inferior social standing relative to men. As the study of brain function arose, for example, women were automatically purported to have anatomical deficiencies in the succession of lobes believed to be the seat of reason. When functionalist ideas of variability and individual differences came into vogue, women's lack of achievement in high-prestige areas of endeavour were accounted for by pronouncements of women's lesser variability on a host of traits and abilities. With the Darwinian emphasis on instinct, the restriction of women's roles to that of caretaking was justified by a focus on women's innate maternal instincts. With the ascendancy of psychoanalytic theory, women's psychology was framed in terms of the inherent masochism and inferior morality which inevitably resulted from psychological development based on sexual anatomy. In each case, as theories were called into question, new ones were developed to explain the real reason for women's deviation from an unacknowledged male standard. According to Shields, by failing to identify social obstacles in women's lives, the early schools of psychology served to reinforce social myths which devalued women, and ultimately, to justify a patriarchal status quo which disempowered women.

Naomi Weisstein's landmark 1968 article, "Kinder, Kuche, Kirche as Scientific Law: Psychology Constructs the Female", presented one of the first social constructionist views of gender and critiqued the theories and practice of clinical psychology into the 1960s. According to

Weisstein (1968), "Psychology has nothing to say about what women are really like, what they need and what they want, essentially because psychology does not know." (p. 71) She attributed psychology's failure to understand women (and persons in general) to a pervasive tendency to look for women's inner psychological traits rather than the social context, including social expectations of women and women's place in the power structure, when attempting to described women's psychology. According to Weisstein, psychological theories about women reflected stereotype rather than the immutable truth they purported to describe:

> How are women considered in our culture, and in psychology? They are inconsistent, emotionally unstable, lacking in strong conscience, or superego, weaker, "nurturant" rather than productive, "intuitive", rather than intelligent, and, if they are at all "normal", suited to the home and the family. In short, the list adds up to a typical minority group stereotype of inferiority..." (p. 72)

Weisstein also asserted that in addition to requirements that psychologists evaluate the evidence for and social repercussions of their work, greater social awareness of women's lives and social change for women's liberation:

> Psychologists must realize that it is they who are limiting human potential. They refuse to accept evidence, if they are clinical psychologists, or, if they are rigorous, they assume that people move in a context-free ether, with only their innate dispositions and their individual traits determining what they will do. Until psychologists begin to respect evidence, and until they begin looking at the social contexts in which people move, psychology will have nothing of substance to offer...I don't know what immutable differences exist between men and women apart from differences in their genitals; perhaps there are some other unchangeable differences; probably there are a number of irrelevant differences. but it is clear that until social expectations for men and women are equal, until we provide equal respect for both men and women, our answers to this question will simply reflect our prejudices. (p. 76)

In addition to mainstream clinical theories and practice, developments within the recently emerging subfield of the psychology of women have not been immune from assuming an asocial perspective. In an analysis of research trends since Weisstein's (1968) critique, Mary Crawford

and Jeanne Marecek (1992) argue that the psychology of women, which informs clinical practice, has promoted views of women consistent with the idea of "Woman as Problem or Anomaly". This view, which emphasizes women's unique intrapsychic difficulties, have developed such concepts as "women's fear of success" (Horner, 1970). According to the authors, this research has both feminist and antifeminist ramifications, with its biggest problem stemming from that fact that it has at times neglected the analysis of social context in favour of an emphasis on intrapsychic factors. For example, some of the "fear of success" research has attributed women's problems in society to intrapsychic conflicts, rather than identifying social obstacles to women's achievement and promoting change of these obstacles. Crawford and Marecek have argued, however, that the recent emphasis on the social construction of gender within the psychology of women may play an important role in correcting the error of "Women as Problem" research.

Many individual schools of personality and psychotherapy have been critiqued for paying too little attention to the role of macrosocial factors in shaping human behaviour (Okun, 1992; Kantrowitz & Ballou, 1992; Prilleltensky, 1992; Prilleltensky, 1989; Waterhouse, 1993; Greenspan, 1993; Lerman, 1986). The earliest and most obvious target of these criticisms was Freudian psychoanalytic theory and practice, with its emphasis upon biological and psychic determinism of behaviour. According to this framework, males' and females' differing psychological reactions to their sexual anatomy are purported to lead to universal and immutable gender differences in personality, morality, and behaviour (Freud, 1925/1964). The role of unconscious defenses, conflicts, wishes, and innate drives are also emphasized as primary motivators of behaviour (Freud, 1901/1976), and the role of society, at least apart from the microlevel of the family, tends to be de-emphasized. The tendency for Freudian thought to attribute behaviour to intrapsychic, asocial causes is perhaps most apparent when applied to

women. Freudian theory described women as inherently masochistic, maternal, and less moral than men, as a result of universal and immutable stages of female psychosexual development. Little attention to power or social forces is evidenced, and an observation by John Dewey (1957, cited in Weisstein, 1968) observation on psychoanalysis merits attention in this regard:

> The treatment of sex by psychoanalysis is most instructive, for it flagrantly exhibits both the consequences of artificial simplification and the transformation of social results into psychic causes. Writers, usually male, hold forth on the psychology of women, as if they were dealing with a Platonic universal entity, although they habitually treat men as individuals, varying with structure and environment. They treat phenomena which are peculiarly symptoms of civilization of the West at the present time as if they were the necessary effects of fixed nature impulses on human nature. (pp.143-144).

Other psychodynamic approaches following Freud have also been critiqued as lacking an awareness of the social context of women's lives. For example, Jungian perspectives that emphasize the role of dichotomous, unconscious, ahistorical, male and female mental archetypes in the development of sex-typed behaviour (Goldenberg, 1976; Romaniello, 1992) have also been criticized as too asocial and intrapsychic. Object relations theories have also been criticized for promoting overly intrapsychic models of human development which divert attention from issues of culture and power (Cushman, 1995; Okun, 1992)

Although initially seen as potentially more sensitive to environmental factors than psychodynamic approaches, humanistic (Lerman, 1992; Prilleltensky, 1992; Waterhouse, 1993), cognitive-behavioural (Kantrowitz & Ballou, 1992), and family therapies (Goldner, 1985; Lerner, 1988; Hare-Mustin, 1978; Walters, Carter, Papp, & Silverstein, 1990; Pravder-Mirkin, 1990) have also been criticized for failing to account for the role of broader social factors such as the devaluation of women in the development of women's distress. Prilleltensky (1992) and Waterhouse (1993) have argued that the intense focus on the individual and emphasis on self-

actualization inherent in humanistic theory and therapy leads to a neglect of real structural obstacles to women's autonomy and mental health. Using her crisis work with sexually assaulted women as a basis for her observations, Waterhouse argues that humanistic psychology is based upon liberal humanist philosophies of free will and choice, options which have traditionally been more available to men than women such as her clients, who live with greater constraints upon their sexuality and freedom of movement because of fears of violence and other social obstacles. As a result, Waterman argues that humanistic psychology's emphases on the importance of self-exploration, personal growth, and self-determination is a naive view which ignores the social constraints affecting women's power and emotional health, and as a result, may set women up to fail. In addition, the tendency for some humanistic psychologists to promote self-actualization as a method for improving problems within society at large is argued to seriously misunderstand issues of power underlying societal problems and to de-emphasize the need for more tangible social reform (Prilleltensky, 1989).

Cognitive-behavioural theories' emphasis on social learning and the environmental determinants of behaviour was met with initial enthusiasm by feminists. These theorists hoped that cognitive-behavioural therapy theories could elucidate the ways in which gender-role related behaviours and conflicts were linked to differential patterns of reinforcement, and could ultimately help women transcend the constraints of socialization (Fodor, 1988, Kantrowitz & Ballou, 1992). The movement from behaviourism to cognitivism to cognitive-behaviourism to constructivism broadened the factors typically associated with pathology from the immediate environmental reinforcement to thoughts, expectations, family, and more recently, culture. Several critics have argued, however, that the promise offered by cognitive therapies have largely not been realized. More traditional, rational cognitive-behavioural theories, as well as many constructivist therapies,

have largely failed to explore and challenge the larger political and social environment to which people are subjected (Fish, 1993; Hare-Mustin, 1998; Kantrowitz & Ballou, 1992). Instead, some have argued that the focus within these therapies has generally been the adjustment of individuals to existing environmental conditions (Kantrowitz & Ballou, 1992). Others have argued that the concepts and abstract jargon used in these theories (e.g., reinforcement, schemas), its emphasis upon the use of the objective scientific method in therapy and research, idealization of rationality, and the location of causes of distress in "irrational" thoughts reflect dominant values which obfuscate the relation of social injustice to distress (Kantrowitz & Ballou, 1992; Prilleltensky, 1989). Such critics have pointed to a need to develop theories aimed at examining and potentially altering the setting instead of changing the person.

While the systemic potential of family systems approaches to assessment and treatment were similarly praised and initially spared from criticism, critiques of family therapy's largely asocial, depoliticized nature have increasingly emerged and been debated (Goldner, 1985; Hare-Mustin, 1978; Lerner, 1988; Walters et al., 1990; Pravder-Mirkin, 1990). In general, critics have argued that despite claims to be systemic, family systems theory largely ignores the influence of larger society on family functioning (Lerner, 1987; Walters et al., 1990; Pravder-Mirkin, 1990). More specifically, points of contention have included the structural school's concept of circularity of family structure and function, which assumes that all roles within a given family system are theoretically interchangeable amongst members. According to critics (e.g., Pravder-Mirkin, 1990) such concepts miss the ways in which gender-based power differentials and role expectations shape family functioning and pathology (such as the ways in which the tradition of male dominance influences wife abuse; Goldner, 1985, Simola, 1992). In addition, structural concepts such as enmeshment (a term used to characterize excessively close relationships between family

members) and the Bowenian concept of differentiation (used to characterize a state of emotional independence from others) have been critiqued as reflecting androcentric bias and a lack of appreciation for the social pressures put on women to assume primary responsibility for child care. Similarly, Goldner (1985) has argued that the typical family therapy pattern of the overinvolved mother and distant father reflect a historically and culturally based family structure influenced by the economic environment in interaction with gender-based power differences and different social expectations for men and women. The usual tactic of encouraging mothers to back away to let the father move in has been seen as implicitly blaming of women. In this way, Goldner argues that family therapists both use women's investment in families to gain access and intervene in therapy, and then pathologize the same behaviour they have exploited. In sum, without a fuller appreciation of larger social influences on family structure and functioning, these critics argue, systems theory is "a map that does not fit the terrain" of the family (Goldner, 1985), which pathologizes women for roles they were socialized to take, and reinforces traditional family patterns that disempower women.

### *Reasons for Clinical Psychology's Inattention to the Social Factors Underlying Women's Distress*

Some accounts of psychology's inattention to gender and power have emphasized the role of prevailing cultural values in shaping the individualistic focus its theories and practices (Bohan, 1992; Cushman, 1995; Hare-Mustin & Marecek, 1990; Prilleltensky, 1989). The development of modern psychotherapy has been inextricably intertwined with the cultural history of North America, and as a result, has been influenced by prevailing values such as liberal humanism, consumerism, and logical positivism. It has been argued that in the developed countries of the

western world, contemporary social and political institutions enshrine liberal humanistic values more than any other competing values and principles (Frazer & Lacey, 1993). This prevailing cultural philosophy has been implicated in psychology's asocial focus (Kitzinger, 1987, 1989). Though not a simple, unified, completely coherent and stable set of doctrines, liberal humanism promotes the idea that citizens possess an essential, universal human self that is separate from and transcends society (Frazer & Lacey, 1993; Kim, 1995). This essential self possesses free will and an innate drive toward self-actualization (or consumption; see Cushman, 1995), and within liberal societies the goal of striving for the fulfillment of individual needs is raised to the level of a moral issue (Frazer & Lacey, 1993; Kitzinger, 1987). Within liberal thought, society is constructed as an aggregate of bounded individuals, and power is viewed both in positive terms as something which drives individual self-actualization, and as something negative which should be constrained by individuals in order to prevent the denial of the individual rights of others (Cobrin, 1995). With regard to the exercise of state power and the proper definition of the 'political', liberal humanism also emphasizes a distinction between the personal, private, individual and microsocial realm, and the public, political sphere (Cobrin, 1995, Frazer & Lacey, 1993).

Many feminist, Marxist, and other critics have criticized the liberal emphasis on individuality for promoting a blindness to issues of social power. Though liberalism has been framed as a philosophy of liberation, these critics have argued that the liberal emphasis on individual rights can lead to the perpetuation of oppression by race, gender, or class (Frazer & Lacey, 1993). Similarly, critics have argued that the brand of individualism that is promoted in liberal western thinking has led psychology in general, and psychotherapy in particular, to overemphasize individual, intrapsychic and microsocial dynamics as determinants of behaviour. In contrast, psychologists' attention to issues such as gender and power in clients' distress is diminished. In

addition to framing the appropriate subject of psychology, liberal humanism is also seen to shape the goals of therapy to emphasize personal and self-actualization rather the promotion of more contextualized view of distress (Hare-Mustin & Marecek, 1990a; Prilleltensky, 1994, ).

The liberal humanist tradition in western society has been linked to the promotion of logical positivistic views of reality, science, and psychology (Frazer & Lacey, 1993). A positivist view has also been implicated in psychology's lack of attention the social context of distress. The positivist philosophy underlying western psychology assumes that an observable, ahistorical truth exists which is separable from both the context in which it is found and the values of any observer. Such objective knowledge can only be known by careful observation via strict adherence to a well-defined scientific method. This method emphasizes the reduction and isolation of phenomena within controlled experiments, designed to separate phenomena of interest from "nuisance" context variables thought to be of little import. In this way, scientific psychology claims to be able to determine uncontaminated cause-and-effect relations and ahistorical, universal laws of behaviour. In addition, because of its emphasis on observation and absolute truth, positivistic science claims to be value-free (Howard, 1985; Longino, 1983, 1986, cited in Bohan, 1992).

The positivist emphasis on an ahistorical truth existing separately from context and observer stands in contrast to philosophies of science which view reality as multiply constructed, inherently suffused with values, and political in nature (e.g., Berger & Luckman, 1966). Critics of positivism argue against a conception of truth as absolute and independent of human values, and claim that the particular picture of reality that dominates at any particular time is a matter of power, with dominant groups having the power to define reality for everyone (e.g., Miller, 1986). As a result, science is seen as a human enterprise which is not, and should not be taken to be

value-free. Rather, critics argue that the values inherent in any research should be explicated for potential impacts on society.

Many theorists (e.g., Albee, 1986; Caplan & Nelson, 1973; Fine, 1985; Mednick, 1989; Prilleltensky, 1989) have argued that the positivist tendency to isolate phenomena from the contexts in which they occur limits psychological theory to a focus on individual behaviour. In turn, this focus ultimately disempowers individuals whose oppression would be evident through an examination of context. According to this argument, the decontextualization associated with positivism often results in theories that blame victims for their own oppression.

Prilleltensky (1989) has also commented that positivism's emphasis on the existence of objective, ahistorical truth and value-neutrality too frequently leads to views of existing social relations as natural and unproblematic rather than characterized by inequality. According to Prilleltensky (1989), positivism's emphasis on objectivity leads social scientists to think that society is as it should be according to universal laws. Adherence to the claim of objectivity obscures the values underlying dominant societal arrangements, and leads to a situation where nondominant, alternative perspectives, such as feminism or socialism, are seen as uniquely political and value-driven, and as distorting the natural state of things. This renders these perspectives unfit for science. In contrast, when dominant perspectives are not seen as value-laden, this has the effect of maintaining a status quo which disadvantages some and privileges others.

In sum, clinical psychology's ties to liberal humanistic philosophy and its reliance on positivistic epistemology has been tied to its lack of attention to the social contexts of behaviour. These perspectives reflect the zeitgeist in which clinical psychology has developed (Cushman, 1995), and the basic model upon which clinical psychologists, as social scientists, are trained. Clinical

psychologists, too, are products of their society and are likely to uphold or be unaware of dominant social discourses rather than challenge them (Kitzinger, 1987; Prilleltensky, 1989). The implications for women, psychology, and society, of this state of affairs, are discussed below.

### *Implications of the Clinical Psychology's Inattention to Sociopolitical Factors*

#### *Implications for Women*

Psychology's lack of self-reflexivity can be thought of as having effects on women as a group, on psychology, on the professionals who practice psychotherapy, and on society as a whole. For women as an oppressed group, the effects of an individualistic psychology which falsely claims to be value-free and acts to separate context from behaviour may be particularly negative. These negative effects include the pathologization of women, the failure to develop theories and therapies reflective of women's life challenges, and ultimately, the maintenance of a status quo in which women are subordinate to men (e.g., Weisstein, 1968).

In general, in a society in which the notions of free will and individual agency are idealized, the existence of gender-based inequality seems less plausible, is rendered less visible, and is resisted when raised as an issue (Hare-Mustin & Marecek, 1990b). Within this context, the reductionistic and decontextualizing effects of positivism have facilitated the creation of blaming, "women as problem" theories (Crawford & Marecek, 1988), such as those describing women's "fear of success" or lack of assertiveness. Such theories are perhaps most prominent in the proliferation of self-help material criticizing women for "Loving too Much", being "codependent", and "addicted" to relationships (Brown, 1990c; Tallen, 1992; Tavris, 1992; van Wormer, 1989). By failing to highlight the context of inequality which may create such problems over the lifetime, critics argue,

these theories often pathologize women and hold them, rather than society, responsible for change.

In addition to charges that women's context and wider cultural view of women are ignored, other critics argued that the view of the individual as separate from society has led to the promotion of independence, separation, and firm ego boundaries as criteria for mental health (Bohan, 1992; Hare-Mustin & Marecek, 1990a). To the extent that women are not equally encouraged to develop these traits, however, these ideals may lead to the marginalization and pathologization of women. While the often-cited Broverman et al. (1972) study finding that men's and women's mental health are judged against separate but unequal standards has been criticized on methodological grounds (Widiger & Settle, 1987), many critics have argued that women have long been defined as an inferior "other" compared with men (Brickman, 1984; Hare-Mustin & Marecek, 1990a, Tavris, 1992).

When issues of gender bias are rendered invisible, psychologists are not likely to examine their theories and practices for bias, theory cannot reflect the important vicissitudes faced by women, and the development of effective psychological services for women is thwarted. According to Ussher (1991) "This results in female clients receiving interventions, which, because of their denial of her real experiences, are at best limited in their outlook, and at worst damaging to the woman's long-term mental health" (Ussher, 1991). In this way, an inability to integrate an appreciation of some of the real obstacles to women's safety and mental health may render a serious disservice to women seeking professional help (see also Waterhouse, 1993).

*Implications for Society*

In general, psychology's role in obscuring the social causes of (women's and men's) distress, promoting victim-blaming theories of distress, and requiring personal adjustment rather than social change, can be seen not only to limit its's potential for healing humanity (Prilleltensky, 1992), but to render it an agent of social control with the power to perpetuate unjust power relations. Perhaps the most lamentable result of psychology's denial of values and individualistic focus is the exclusion of the discipline from greater involvement in debates about the type of society we wish to live in, and the struggle to attain these ideals (Prilleltensky, 1992).

With regard to its role in maintaining patriarchal social relations, psychology may also serve to deprive society in a unique way. Despite contending that some of the psychological attitudes, characteristics, and problems more characteristic of women are the result of socialization into subordinate roles, Miller (1976) argued against overpathologizing these qualities. She felt that a better appreciation and application of some of the benefits inherent in such attitudes as awareness of one's own vulnerability, may be useful for both men and women. Through its inattention to and unintentional support of the social factors which demand and then devalue these tendencies in women, and which punish them even more severely in men (Page, 1987), psychology may prevent the integration believed to result in more flexible models of functioning (Miller, 1976).

*Implications for Clinical Psychology*

Psychology's lack of self-reflexivity also has negative effects upon itself as a discipline and upon the persons who make it a profession. Some have argued that psychology's inattention to gender-related power dynamics in such areas as family assessment has lead to the production of inadequate theory and methods of treatment. As noted earlier, Goldner (1985) referred to this

situation as a case of the "map not fitting the terrain". Such ill-fitting guides may mean that therapy is less effective than it potentially could be, a situation which may lead to frustration and disillusionment on the part of practitioners (Goldner, 1985; Ussher, 1990). Ussher (1990), for example, speculated on the feelings of helplessness experienced by clinical psychologists who find that they cannot reconcile their own understanding of women's distress with that which is provided within the psychological framework. According to this author, "Being trained to facilitate the extinction of an anxiety response, through systematic desensitization, in a woman who clearly is oppressed through her family and wider social experiences, is likely an offensive and alienating experience for many trainees." (Ussher, 1990, p. 67). Such alienation may be an inevitable reaction when the discipline in which they work largely ignores a whole part of the explanation of behaviour and distress. One must ask whether alternative theories exist which allow for an a more explicit consideration of the powerlessness and alienation produced by social realities individuals face. One of these alternatives is feminist therapy, and it is to this group of theories that I now turn.

## An Alternative: Feminist Therapy

Feminist therapy emerged as an alternative to mainstream psychotherapy in the 1960s and 1970s. Emerging from feminist consciousness-raising (CR) groups, feminist therapy has at its core an a view of women's distress as at least partly caused by their subordinate position within society (Hanisch, 1971). Over the past thirty years, feminist therapy has evolved from offering critiques of existing forms of therapy and exploring ways in which women's political power was linked to personal dilemmas, to the implementation of multifaceted forms of therapeutic practice (Enns, 1993; 1997). Feminism and feminist therapy reflect not a single monolithic theory, but a

set of principles that guide the format and conduct of therapy. As a result, feminist therapies exist as a variety of approaches with different emphases and techniques (Enns, 1993, 1997).

Feminist therapies have several common themes. The most important of these includes an awareness of the range of ways in which traditional gender role socialization and sexism may affect women within a male-dominated society (Cammaert & Larson, 1988; Enns, 1997). In addition, attention is paid to the ways in which power is played out within the therapeutic relationship. Expecting that interactions within the therapy hour may mirror traditional, disempowering patterns in which women seek help, and receive "expert" advice, feminist therapists have attempted to develop more egalitarian relationships with their clients. Feminist therapy also involves an awareness of the ways in which structural factors other than gender (e.g., race, age, social class) intersect with gender to create different social experiences and problems for a wide range of women (Enns, 1997).

Feminist therapies also tend to have similar goals. In general, a client's adjustment and conformity to existing negative social pressures is not a goal of therapy, but rather therapy focuses on helping individuals to identify, explore, and overcome oppressive social pressures. In addition, a goal of feminist therapies is social change (Weiner, 1998), with the ultimate goal being the elimination of patriarchal power structures that constrain both women's and men's personal growth. For some therapists, personal commitment to social activism is undertaken separately but concurrently with therapy. For others, social activism may be a goal encouraged for clients.

Feminist principles have been used to transform existing approaches including cognitive-behavioural (Wolfe, 1985, 1995), psychodynamic (Chodorow, 1978; Prozan, 1993), family therapy (Luepnitz, 1988; Pravder-Mirkin, 1990; Walters et al., 1990) and Gestalt approaches (Polster, 1974), and most recently, have been integrated with postmodern philosophies such as

social constructionism and conceptualized from the point of view of eclecticism (Enns, 1997). Adherence to liberal, radical, socialist, or cultural forms of feminism also shape the emphases, goals, and techniques of feminist therapy (Enns, 1997). Despite these distinctions, however, ways in which a sociopolitical analysis can shape the overall process of therapy and specific techniques have often not been operationalized in the literature (Hill & Ballou, 1998). This has led to difficulties for practitioners wishing to employ such a framework in their work with clients. Responding to this issue, the 1998 volume of the journal Women and Therapy, for example, focused attention on the integration of feminist political analysis in therapy. In this volume, Morrow and Hauxhurst (1998) described a sophisticated comprehensive model for integrating political analysis and empowerment techniques across interrelated macrosocial, microsocial, and individual dimensions. In order to begin to describe ways in which feminist principles are used in therapy, Hill and Ballou (1998) and Weiner (1998) surveyed feminist therapists about creative ways in which feminist principles are brought in to transform the environment, format and process of therapy. Results suggest, however, that attempts to transform the "surface" or format level of therapy are more easily accomplished than the integration of feminism with therapy process. Such findings suggest a need for further study of the ways in which clinicians integrate social and gender awareness in their work. It also points to a need to examine the reasons for and implications for women of the types of integration they achieve.

There remains a need for further research into the ways in which a sociopolitical analysis of distress can be made to inform clinical practice. Research that examines the creative ways in which clinicians may be attempting to integrate feminist principles into therapy is needed to guide the development of the field (Hill & Ballou, 1998).

### *Evaluation of Feminist Therapies*

Like the theories they have critiqued and sought to replace, feminist therapies have not been immune to critique and deconstruction. In particular, feminist therapies have been accused of committing the same errors and producing the same disempowering effects as the more traditional therapies they have always condemned. Some of these criticisms involve concerns that cultural-feminism-inspired theories emphasizing women's unique psychology (such as the "self-in-relation" models emphasized by the Stone Center; Miller, 1986) ultimately feeds into a patriarchal system based on notions of essential gender differences (Westkott, 1989, 1990). Others, such as Kitzinger and Perkins (1993; Kitzinger, 1992; Perkins, 1991, 1992), do not single out any particular form of feminist therapy, but charge that all feminist therapies are unavoidably and inherently patriarchal. According to these critics, the focus on individual rather than social solutions inherent in therapy, and therapy's tendency to depoliticize and psychologize discrimination by focusing on issues such as internalized (rather than actual social) oppression, ultimately render feminist therapy harmful to women. These authors also comment that therapy replaces and hence "professionalizes" caring and support within falsely egalitarian relationships, and contend that these activities are more appropriately the role of communities. Caplan (1992) has similarly argued that feminist therapists have increasingly refrained from encouraging any social action on the part of their clients because this is seen as the inappropriate imposition of values. According to Caplan, this attitude reveals therapists' untenable view that other actions are harmless and value-free. Greenspan (1995) has likewise expressed fears about the depoliticizing effects of the professionalization of therapy, while Mowbray (1995) has linked the quieting of calls for social action to the elimination of some of the more blatant forms of sexist therapy over the past two decades. All of these critics call for a repoliticization of women's distress.

In addition to criticisms based on the depoliticized nature of feminist therapy, other critics have called attention to other possibly negative effects of feminist therapy techniques. Krawitz and Watson (1997) have questioned whether bringing a sociopolitical analysis into therapy may sometimes unwittingly reinforce the defensive and growth-inhibiting use of anger and externalization of blame used by some clients. Further, MacLeod (1994) highlighted the concern that feminist therapy, with its emphasis on women's oppression, might encourage female clients to disavow the ways in which they might dominate others. Still others have expressed concerns about the imposition of political values within feminist therapy. Lakin (1991), for example, questioned whether a stifling of self-determination may occur if feminist analyses are offered in group or individual settings where, despite attempts to equalize power, clients have little authority to disagree and define their experience in alternative ways. In this way, consciousness-raising may lead to the same type of disempowering expert-patient relationship so condemned in alternative approaches. While the criticism about imposition of values could likely be raised about any form of therapy, some have wondered whether feminism's divergence from dominant cultural narratives about gender relations may set feminist therapy clients up to face alienation and social backlash, particularly within subcultures with more rigid and traditional rules about women's place (Krawitz & Watson, 1997). Still others have expressed needs for therapy to decentre gender as the primary variable of analysis, claiming that in many cases, issues of race and class-based oppression are more central (MacLeod, 1994).

## The Need to Study Clinical Psychologists' Beliefs and Practices

While philosophical battles have been waged for and against mainstream theory and alternative feminist theory, very little research has investigated practitioners' views about and their practical

application of a sociopolitical model of women's distress in clinical work. While there have been recent efforts to better understand feminist therapists' utilization of certain therapy techniques (e.g., Hill & Ballou, 1998; Marecek, 1999; Marecek & Kravetz, 1998a,b), no research to date has addressed a wider range of clinicians' incorporation of sociopolitical approaches in therapy, or contextual factors which affect it.

Research addressing a range of clinicians' incorporation of a sociopolitical model of women's distress in clinical work, however, could be very useful in encouraging broad debate about the ways in which women can be helped best by therapy. For example, studying clinician's views about women's social position, its effects on women's mental health, and the use of psychotherapy in this context will provide a rich, nuanced answer to longstanding feminist criticisms that psychology overlooks social factors in women's distress. This kind of research could also guide the development of better, specific therapy practices. For example, identification of some creative and perhaps undocumented ways in which practitioners incorporate their appreciation of gender and power in their work could guide the development of better approaches to therapy. The opportunity to consider individuals' concerns about the incorporation of certain sociopolitical techniques may also inform the development of guidelines for therapies that best help women. Further, analysis of differing views about the incorporation of a sociopolitical approach in therapy may also permit the identification of conflicting, underlying values and assumptions. Highlighting these values and assumptions may help readers assess the repercussions of their own work in such a way that they can self-reflexively bring their clinical work in line with their own personally-held values, goals, and assumptions. The unavoidable political repercussions of any form of therapy demands reflexivity about one's own values and their relation to one's clinical work (Prilleltensky, 1993). According to Laura Brown (1994), "Those constructs that a particular model names and

defines become real, present, and observable in the psychotherapy process of practitioners who use that model." (p.48). These models ultimately have important implications for the health of women, psychology, and society as a whole. It is hoped that this study may encourage readers to reflect about the issues of values in their work.

## Overview of the Present Study

As noted earlier, my interest in conducting research on this topic stemmed from my own struggle, as a novice therapist, to decide how to best incorporate my feminist values in my clinical work. Upon entering graduate school, I was disappointed by the lack of attention given to this issue in standard texts and my clinical classes. Pursuing my own path, I became intrigued by the variety of themes that emerged in informal conversations I would have with fellow students and mental health professionals. These themes were both positively and negatively oriented toward the use of feminist approaches, and the individuals with whom I spoke offered qualifications and warnings about the use of certain techniques over others, and described practices, attitudes, and opinions that I thought would be important to capture. As individuals who worked hard with different kinds of clients under trying circumstances, the things they had to say seemed important to consider, regardless of whether I ultimately shared their perspective. I became interested in conducting research that would allow me to talk with clinicians about their work and their perspectives and practices pertaining to the incorporation of a sociopolitical model of women's distress in their work. I wanted an opportunity to elicit clinicians' viewpoints and collect descriptions of techniques with an eye to making sense of the themes I was hearing, so that I could consider their underlying assumptions and their implications for my own work. I wanted to develop a framework about clinicians' incorporation of a sociopolitical approach that might

inform myself and others who were interested in this issue. The research described below allowed me, as a student of clinical psychology, to gain information about issues such as whether clinical psychologists paid attention to gender and power, the kinds of sociopolitically-informed techniques that existed and how they were concretely applied, and a variety of related philosophical and other contextual issues that were important to consider. The aim of the research is ultimately to inform debate and theory about the best ways in which therapy can help women.

The present study sought, through in-depth interview methods, to engage clinicians in an exploration of the models they found useful in conceptualizing and treating women's distress, with an emphasis on their views about the status of women in society, the relationship between this status and women's distress, and the ways in which they do or do not shape their therapeutic practices in accordance with these views. The goal was to facilitate a range of views, observations, and descriptions of techniques to encourage and inform debate in the therapy literature. This study offers a unique contribution to debate in this area because it sought to find a range of views among a wide range of clinicians in different settings with different orientations, not just those explicitly labeling themselves as feminist therapists. It was hoped that information gathered from clinicians who rejected, were relatively unaware of or untrained in, or otherwise did not use a strongly sociopolitical approach could provide important information about this issue.

## Rationale Behind the Present Methodology

The decision to develop a qualitative interview study of clinicians' incorporation of a sociopolitical analysis in conceptualizing and treating women's distress was driven by both pragmatic and theoretical concerns. First, while some scales measuring feminist therapy

techniques and values do exist (e.g., Beardsley & Morrow, 1998; Chaney & Piercey, 1988; Juntanen, Atkinson, Reyes, & Gutierrez, 1994), problems with inadequate psychometric properties and an insufficient breadth limit their usefulness. In addition, the relative scarcity of descriptive literature pertaining to the incorporation of a sociopolitical analysis in therapy with women (though increasing) suggests that a qualitative, open-ended approach may lead to the discovery of creative new ways of taking gender and power into account that are not currently captured by the literature. Overall, the use of interviews was deemed most likely to provide opportunities for capturing new, previously unelaborated perspectives and also the richest, most contextualized data. In this way, clinicians' attitudes and practices, their rationales for taking these stances, along with examples from past experiences, and all the implications and paradoxes inherent in these accounts, can be explored and presented in their complexity to better expand our knowledge and to create debate about how to create therapy that better serves women.

Grounded theory (Glaser, 1978, 1996; Strauss & Glaser, 1967; Rennie et al., 1988; Rennie, 1995, 1998 a,b, 1999, 2000) was chosen as the analytic method for deriving themes from interview data for several reasons. These included the fact that grounded theory methodology consists of well-articulated, systematic steps for data analysis, and stresses the importance of explaining and describing problems in thick, comprehensive, contextualized ways. In addition, while grounded theory emphasizes attending to the meanings respondents give to their own experience, it also permits the researcher to describe and explain problems at an abstract level and to potentially interpret participants' experiences in ways that may not be congruent with their own understanding (Charmaz, 1983; Rennie et al., 1988). For example, in Rennie et al.'s 1988 study of clients' experiences of therapy, the category of "client defensiveness" emerged as part of the theoretical framework. Although participants in the study did not frame their experiences in this

way, Rennie and colleagues believed this label to be a useful addition to their theory of psychotherapy process. Although my view is that the data which emphasizes the participants' own points of views will encourage the most meaningful debate about women's mental health needs, I also recognized that some participants may be reluctant to acknowledge views about women and therapy that are not "politically correct". While other efforts were taken to avoid this bias from limiting the resulting analysis, it was also important that the methodology used allowed and encouraged me to explicitly acknowledge my own interpretation of the data.

## Research Questions

Most research involves a statement of hypotheses. The present study utilized an exploratory qualitative approach involving analysis of interview data via grounded theory techniques (Smith, 1995; Charmaz, 1995; Strauss & Corbin, 1967; Glaser, 1978, 1992; Rennie et al., 1988, 1998a,b, 1999). As one goal of qualitative research is to obtain a new picture of a phenomenon without the constraints of prior theory and research (Gilgun, 1994), and because the findings will ultimately be grounded in the data and hence are presently unknowable, I based my study on a few overarching research questions rather than hypotheses which would require prior theory (recommended by Creswell, 1994). My overall research questions were as follows:

1. How do clinical psychologists characterize the status of women in contemporary society?
2. Do clinical psychologists see women's mental health problems as (at least in part) socially-based? If so, how so? If not, why not? What models do they use to conceptualize female clients' distress?
3. How does a sociopolitical analysis of women's distress influence clinical work?
4. What appear to be some of the contextual factors that affect the manner in which a

sociopolitical analysis of women's distress is incorporated in therapy?

# CHAPTER II

# METHOD

## *Procedure*

*Participants.* Twenty-five participants from several cities in Ontario and Michigan were interviewed for this study. The overall size of the sample was chosen on the basis of both theoretical saturation and pragmatic grounds about limiting what was an extensive analysis. Nine participants were male, and sixteen were female. The age of participants ranged from 35 to 61, with the mean age being 48.68 years. Twenty-three participants had Ph.D. degrees, and two had M.A. degrees. Participants' level of experience ranged from 5 to 32 years, with the average level of experience being 18.97 years.

*Recruitment.* Recruitment of subjects proceeded on a sequential basis through snowball, opportunistic, and theoretical sampling. Initially, I contacted professionals with whom I had some prior contact and felt were willing and able to recommend professionals who could be approached to offer different views. Following the tradition of theoretical sampling, (Guba & Lincoln, 1985, 1989) which aims to facilitate the capture of a diverse range of views about a topic, I sought participants in a sequential fashion after having partially analyzed prior interviews. In this way, I was able to recruit more selectively those participants who provided different information to build upon previous analysis. For example, as data collection and analysis proceeded, I sought (and participating clinicians would nominate) clinicians who exhibited different characteristics hypothesized to be related to the incorporation of a sociopolitical approach in therapy with women. For example, after participants reported that clinicians working with disadvantaged women might be particularly likely to assume a politicized clinical approach, I interviewed two clinicians working with those populations. I also sought out clinicians whom peers described as

more conservative in their worldviews generally, and in their views about issues of feminism and women's therapy specifically. While most clinicians noted that they did not know their peers' attitudes about the latter (an interesting point to note in itself), I was able to find some participants in this way, and their views helped further enlarge the overall picture of taking a sociopolitical approach in therapy with women.

Although following theoretical sampling procedures, I also made some attempts to ensure that my sample was not highly skewed with individuals who could be considered to be outliers on any clinical characteristic (e.g., all feminist therapists). I attempted to ensure that I included participants who worked with a variety of client populations, and who had a variety of levels of experience, training backgrounds, theoretical orientations, work settings, areas of expertise, and client populations. This kind of coverage was accomplished by developing rough guidelines which emphasized factors such as age, gender, place of training, years of experience, work setting and clientele (e.g., medical settings, generalist private practices, work with disadvantaged groups, work with women in women-focused programs, etc.). The guidelines were also based on clinical descriptors standardized by the Canadian Register of Health Service Providers in Psychology (CRHSPP), a public users' manual used to classify and advertise clinical psychologists on these factors. With the use of these rough guidelines, I classified individual clinicians that I had interviewed and monitored the characteristics of the emerging sample in order to ensure some breadth of representation and also a relative predominance of clinicians who likely represented the statistical "middle of the road" in terms of their clinical orientations and activities. This step helped to ensure broad coverage to best elucidate the topic area. In addition, although the sample was not a random one which could permit definitive generalizations to be made to the "average" clinician, I did want my results to have some reasonable "suggestive" value to provide a picture of

the relative popularity of clinicians' use of different kinds of sociopolitical approaches with women in therapy. Following the tradition of theoretical sampling, interviewing stopped when the themes derived from interviews became saturated, that is, when new perspectives ceased to emerge (Guba & Lincoln, 1989).

*Interviews.* Participants volunteered to be interviewed on a single occasion lasting approximately one to one and one-half hours. Interviews took place at the participants' place of employment, and in one case, in a participant's home. They were recorded along with the interviewer's thoughts before and after the interviews. The tapes were later transcribed verbatim for analysis and interviews were associated with neutral pseudonyms to help ensure confidentiality.

*Interview protocol.* During the interviews, questions focused on the participants' clinical experience, models of therapy found to be helpful, and the participants' overall views about the causes of and best treatments for women's distress. Other questions addressed the impact of gender-related social power differences on women's distress, and the ways in which clinicians perceived themselves to address (or not address) these issues in clinical work. An interview template was developed to tap these and related areas (see Appendix C). Prior to beginning formal interviews with participants, the quality of the interview questions were tested in pilot interviews conducted with three volunteer clinicians known to the researcher. After pilot interviews were conducted in the same manner as they would be with formal participants, the volunteers were provided with copies of the interview schedule and provided feedback on the questions and overall experience of the interview. Feedback on the questions and overall experience of the interview was also elicited from participants after formal interviewing began. The few revised questions emerging from this feedback process are also presented in Appendix C.

At all times, clinicians were encouraged to present their views and to offer examples from their own clinical work. In order to ensure the production of rich data reflecting the participants' own views and concerns, and to prevent the interviewer from overly determining the direction and content of the interview, attempts were made to follow up on points with probes that encouraged open-ended elaboration (e.g., "Can you tell me more about it?", rather than automatically asking "Who, What, When, Where, or How?"). While it is noted that the interviewer cannot avoid coauthoring responses to some degree (this is true in any research), this more open-ended approach allowed participants greater freedom to move to the issues they deemed to be important to their clinical practice. Overall, this helped ensure that the categories that emerged reflected participants' concerns rather than just my own attempts at full conceptual description (see Glaser, 1992 and Rennie, 1998a,b for a discussion of the importance of letting significant themes "emerge" during data collection and analysis rather than "forcing" an exhaustive description of a subject). At the same time, however, I attempted to actively ask follow up questions, and respectfully searched for variation and inconsistencies in participants' discourse. When themes emerged as relevant to a number of participants, I would also begin to listen for and ask subsequent interviewees about their views about them, adding probes to the end of the interview protocol.

In order to ensure that I was appreciating participants' intended meanings during the interviews, I asked for clarification of statements at several points and also requested feedback on the accuracy of my perceptions of participants' views so that participants could qualify, correct, or add to them. In addition, although I did not conduct systematic attempts to involve participants in the analysis and evaluation of the framework that emerged from the interviews, I was able to get some informal feedback on the validity and utility of my analysis when, after

finishing later interviews, I was able to begin answering questions some participants asked about the kinds of themes that had emerged and accumulated. In order to later contextualize the themes that emerged and help assess their degree and type of validity, participants were also asked questions about their experience of being interviewed. In particular, they were asked about whether they felt pressure to "talk a certain line" during the interviews, whether they had questions about the research, and whether they felt that the views discussed during the interview characterized their general attitudes and clinical practices, as well as those of their colleagues.

# CHAPTER III

# RESULTS

## *Description of the Sample*

All participants described their theoretical orientation as eclectic. Fifteen participants (60%) reported that they used a psychodynamic approach, thirteen (52%) used a cognitive-behavioural approach, eight (32%) used a humanistic approach, four (16%) used family systems approaches, and two participants (8%) used narrative or social constructionist approaches with clients. (Percentages sum to greater than 100% as a reflection of participants' eclectic orientation). Twelve participants (48%) in the sample described feminism or women's issues as important to their practice. Of this group of twelve, four (16% of the total sample) female participants explicitly labeled themselves as a "feminist therapist", while four others (16% of the total sample) did not identify as feminist therapists, but labeled themselves as specializing in "women's issues". At some point in their interviews, four other participants (16%; two women and two men) contextualized their interview responses by pointing out that they considered themselves to be "feminists" or otherwise interested in feminism or gender issues.

The 16% rate of endorsement of a feminist therapist orientation in this sample is higher than the 7.84% rate calculated by comparing the number of self-identified feminist therapists listed in the CRHSPP manual for Ontario against the overall number of Ontario clinicians. The 16% rate of participants who did not self-label as feminist therapists but who claimed an area of specialization in women's issues was more similar to the 13.50% rate calculated for Ontario clinicians listed in the CRHSPP manual. No statistics currently exist as to the rates of self-identified "feminism" or interest in gender issues among Ontario clinicians. These results suggest

that while feminism and women's issues were salient factors for a large proportion of the present sample, the sample was likely not grossly biased in terms of a feminist therapy orientation.

Regarding the settings in which participants worked, most worked in more than one setting. For example, virtually all who worked in a hospital or other organizational setting also consulted and did private practice work. The picture becomes even more complex when one considers that most participants had worked in several settings over the course of their careers. At the time of the interview, eleven participants (40%) worked predominantly in private practice, while eight (24%) worked predominantly in hospital in- or outpatient mental health programs. Three participants (12%) worked in university counseling service programs, while three (12%) worked in clinical health psychology programs. Two participants (8%) worked in a women's mental health program, while one (4%) worked in a community health centre that was not affiliated with a hospital. Clinicians also engaged in a wide range of clinical and professional activities. Such activities included psychological assessment and long- and short-term individual, group, couple, and family therapy, teaching and supervision of student therapists, custody and access work, clinical health psychology work with a wide range of acute and chronic medical conditions, psychoeducational assessment and consultation, vocational and career counseling, clinical research, community outreach work, and administrative work within hospitals and other settings. Client populations seen included children, adolescents, and adults, individuals with a wide range of mental health problems including mood and anxiety disorders, dissociative and personality disorders, eating disorders, and a wide range of other mental and physical health problems such as pain disorders, sleep disorders, cancer, and other chronic illness. Participants also saw clients from a wide range of socioeconomic and cultural backgrounds. A chart designed to help readers organize clients' characteristics as they read subsequent analyses is presented in Table 1. The

reader should note that the names given to participants represent pseudonyms given by the researcher to protect participants' anonymity. In the table, participants were roughly organized on the basis of their identification as feminist therapists, feminists, or their interest in women's issues and gender. Within these two categories, participants are listed in alphabetical order.

*Analysis*

The analysis of the interview data proceeded in three steps. First, following Rennie, Phillips, and Quartaro's (1988) conceptualization of grounded theory, which is based upon the work of Glaser and Strauss (1967), and Glaser (1978, 1992; see also Elliott, Fischer, & Rennie, 1999; Rennie, 1995, 1998a,b, 2000), transcribed interviews were broken into meaning units consisting of relatively self-contained thoughts on different topics. In order to ensure the validity of the framework of themes emerging from the data, attempts were made to ensure broad coverage of the data; that is, all interview data were analyzed, and large chunks of data were not omitted from analysis. Maintaining each participant's meaning units in separate files, these meaning units were then summarized according to summary statements made up of a few sentences. Each statement was then labeled according to the descriptive concepts. These concepts were then organized into categories or themes that attempted to explain the descriptive concepts contained within them and the relationships between them. To keep the themes grounded in participants' words, I continually engaged in a process of questioning whether I was overstating or taking words out of context. Finally, themes derived from individual participants' interviews were condensed into a cross-participant, hierarchical taxonomy of themes. After this framework was completed, entire interviews were reread to help assess the coverage and credibility of the more abstract, integrative framework of themes that resulting from the analysis.[1]

Table 1.

Participant Characteristics

| Name | Theoretical Orientation | Work Setting(s) |
|---|---|---|
| Identifies as Feminist Therapist, Feminist, or Specialist in Women's/Gender Issues | | |
| Ellen | CBT, FEM, HUM | Women's Centre |
| Felicia | HUM, FEM | Private, Women's Health Centre |
| Laura | CON* | Private |
| Margaret | HUM, DYN, CBT, SYS** | Community Health Centre |
| Oliver | DYN* | University Psych. Services Private |
| Paula | DYN, CBT* | MHC. Private |
| Quinn | CBT, DYN** | Private |
| Steven | HUM, DYN, SYS** | Private |
| Theresa | CON, DYN, SYS* | Private, MHC |
| Victoria | DYN, CBT** | Private |
| Wendy | HUM, DYN, CBT, FEM | Private |
| Yvette | DYN, FEM | University Psych. Services Private |
| Does not Identify as Feminist Therapist, Feminist, or Specialist in Women's/Gender Issues | | |
| Adam | DYN, CBT | MHC, Private |
| Brian | CBT | Medical |
| Chris | CBT, HUM | Medical, Private |
| Diane | DYN | MHC, Private |
| Grace | DYN, CBT | MHC, Private |
| Henry | CBT, SYS | Private, MHC |
| Ian | DYN | MHC, Private |

table continues

| Name | Theoretical Orientation | Work Setting(s) |
|---|---|---|
| Jane | DYN | MHC |
| Kathleen | DYN | Private |
| Nadine | CBT | Forensic |
| Robert | CBT, DYN | Private |
| Xavier | DYN | Private |
| Zoe | CBT, HUM, DYN | MHC |

Note. **=claims area of expertise in "women's issues"; *=described self as "feminist"or interested in feminism and/or gender issues; CBT=cognitive-behavioural; CON=constructivist/narrative; DYN=psychodynamic; FEM=feminist therapist; HUM=existential-humanistic; MHC=outpatient mental health centre; SYS=family/systems approaches.

## Themes Derived from Qualitative Analysis of Interview Data

Two main themes emerged from an analysis of participants' interviews. The first theme pertained to participants' descriptions of the ways in which their appreciation of sociopolitical factors believed to be associated with women's distress shaped their approach in clinical work. The second theme pertained to participants' descriptions of and the researcher's observations about factors which may account for differences in participants' emphasis on sociopolitical models in clinical work, as well as their choice of which forms of sociopolitical approaches or techniques to use with female clients. A summary outline of the themes and subthemes emerging from participants' interviews is presented below (see Figure 1). These themes and their relationship are subsequently discussed in further detail. Throughout the results section, themes emerging from interviews are illustrated by excerpts from participants' interviews. For the sake of clarity and conciseness, I chose to present excerpts that conveyed themes most clearly and centrally. At the same time, however, I also attempted to make sure that all participants' voices were presented at some point or other, rather than simply allowing the voices of the most articulate participants to dominate. The inclusion of interview excerpts will allow readers to evaluate the accuracy and usefulness of the present framework. Following each excerpt, line notes (eg.,1-56) are indicated to allow potential audits of interviews to further assess the plausibility of the integrative framework described below. A general description of each participant in terms of their theoretical orientation and primary place of work will be provided the first time an excerpt from their interview is presented. This will enable the reader to develop a sense of the different perspectives and characters emerging within the framework. In addition, in order to give the reader a sense of the centrality of or degree of consensus on certain themes, the numbers of participants endorsing specific perspectives or techniques are indicated where appropriate.

Figure 1.

List of Emergent Themes: Incorporating a Sociopolitical Analysis in Clinical Work

Theme 1: Incorporating a Sociopolitical Approach in Clinical Work

- Assessment
  - Exploring and legitimizing the issue of gender
  - Avoiding victim-blame in diagnosis
- Structural/Format Aspects of Therapy
- The Therapist's Way of Being Within the Clinical Relationship
  - Empathy
  - Forming a safe, collaborative relationship
    - De-emphasizing the therapist's power
    - Honouring the client's perspective
  - Client advocacy
- Highlighting Gender and the Sociopolitical Context in Therapy
  - Degree of emphasis on gender and the sociopolitical context
  - Exploring the social context and finding your own way
  - Normalizing and depathologizing
  - Synthesizing multiple explorations
  - Exploring the social repercussions of different solutions
  - Using a variety of media and methods
  - Teaching or inviting
- Resolving Intrapsychic Conflicts Associated with Gender and Power
- Going Beyond Gender-Role Socialization: Learning New Skills and Attitudes
- Beyond Traditional Psychotherapy

figure continues

Figure 1. Cont'd.

Theme II: Factors Related to Clinicians' Incorporation of a Sociopolitical Analysis in Clinical Work

- Perspectives on the Relationship Between Society and Women's Distress
  - Gender-based societal factors harm women
  - Types of effects: intra and interpersonal distress
  - Perceived degree of influence on distress
- Emphasis on the Individual and Intrapsychic
  - Concerns about incorporating a sociopolitical approach: you might lose the individual
    - Concerns About degree/dogmatism of a sociopolitical approach
    - Missing the complexity of the individual
    - Resolution of individual issues is the real focus of therapy
    - Group statistics don't tell you about the individual
    - Failing to meet the individual where they're at: imposing your agenda
    - Alienation of clients
    - Categorizing, limiting, and marginalizing women
    - Categorizing women as victims
  - Concerns inspiring the use of a sociopolitical approach: problematizing an individualistic focus
    - Focusing on the individual/intrapsychic is insufficient
    - Lacking empathy and blaming women
    - Benefits of focusing on women and the social context
- Other Factors Influencing the Use/Shape of a Sociopolitical Analysis in Therapy
  - Setting factors: Organizational mandate and climate for feminist work
  - Client factors
    - De-emphasizing consciousness-raising with distressed/borderline clients
    - Gender and power are more visible in group/family/couples therapy
    - The client's awareness of gender/power influences the therapist's emphasis on consciousness-raising
    - Following the client's emphasis and interests
  - Therapist factors
    - Theoretical orientation
    - The therapists' brand of feminism influences a sociopoliticalapproach
    - The therapist's reflections on personal experiences with sexism
    - The therapist's education in sociopolitical approaches to clinical work
  - Theory: Guidance on how to do gender/socially conscious therapy
    - The need for more theory, validated theory, and concrete guidance
    - Available theory on women, society, and distress has helped
  - Broader social factors: Western individualism

*Theme I: Incorporating a Sociopolitical Approach in Clinical Work*

The first major theme derived from the interviews concerned clinicians' claims about the ways in which a sociopolitical analysis shaped their clinical work with women. The subthemes comprising this main category related to participants' approach to assessment, considerations about the structural or format aspects of therapy, and manner of relationship building with clients. Additional subthemes related to ways in which clinicians introduce discussion of sociopolitical issues pertaining to women's distress, their attempts to help clients resolve intrapsychic conflicts believed to be related to sociopolitical factors, and their attempts to help women gain new attitudes and skills, such as greater assertiveness, which were conceptualized as not being emphasized in traditional gender role socialization. In addition, clinician interventions which were guided by a sociopolitical conceptualization of women's distress but which fell outside the traditional parameters of psychotherapy are also presented.

In presenting the range of ways in which clinical work is influenced by a sociopolitical analysis of women's distress, participants discussed techniques, values, and goals of therapy. The approaches described below range along a number of parameters, from the overtly political, direct, and didactic to approaches which may sometimes seem indistinguishable from more traditional psychotherapy techniques, but which were nonetheless described as guided by sociopolitical or feminist values. What all of these approaches and elements have in common is an appreciation of women's social and political context, a context which is considered, at least at some times and areas, to devalue or disadvantage them. It should be noted in advance that the use of these techniques was not restricted to those clinicians who identified themselves as feminists or specialists in women's issues or feminist therapy. It should also be noted that not all clinicians, even those who described themselves as feminist therapists or interested in women's

issues, endorsed all of the techniques described below. Many clinicians embraced certain techniques and rejected others for a wide range of reasons. The extent to which participants viewed a sociopolitical model of women's distress to be a correct or useful approach in therapy with women, as well as their choice of technique when they did see this overall model as a useful one, varied widely and were associated with a number of concerns about the appropriate focus and standards for therapy, and other client, work setting, therapist, and theoretical factors. The aim of the present section is simply to outline the range of sociopolitically-informed techniques or approaches described by participants in this sample. The variety of factors associated with participants' degree of emphasis on sociopolitical models in understanding and treating women generally, as well as their choice of incorporation approaches, will be discussed in subsequent segments of the results section.

*Assessment*

Ten participants indicated that their appreciation of the sociopolitical factors involved in women's distress affected the way in which they conducted initial or ongoing psychological assessment with female clients. A review of their interviews suggests that the assessment process is affected by their outlook in two main ways. The first has to do with the way in which participants gathered and processed information regarding clients, while the second involves clinicians' philosophical attitudes toward the issue of formal diagnosis.

*Exploring and legitimizing the issue of gender.* While most participants in the sample noted that it was important to understand clients' situations as resulting from a variety of factors, eight participants explicitly noted that their appreciation of the sociopolitical context of women's distress influenced the manner in which they gathered and/or valued assessment data provided by

clients. These participants noted that they would ask questions about issues of gender or listen to and attempt to evaluate female clients' concerns with a sociopolitical hypothesis in mind. Some also noted that their appreciation of women's context would lead them to value and ask about client experiences that tended to be devalued or trivialized within the larger culture. For example. Theresa, a narrative therapist working in private practice, noted that she always attempted to see clients' presenting problems from a number of different levels, including the sociopolitical, a perspective she also encourages clients to assume themselves (482-488). Similarly, Margaret, an eclectic clinician working at a community health centre in a disadvantaged neighbourhood, noted that she explicitly attempted to gather information about sociopolitical factors that might potentially influence female clients within the interview (978-982). Oliver, a psychodynamically-oriented clinician working in private practice and university settings, noted that in instances in which clients described experiences of sexism in one realm of their lives, such as the workplace. he would spend time investigating the ways in which similar gender issues were addressed in other realms, such as the family of origin or marital relationship, in both a historical and present context. He described such an approach as a useful way of understanding the degree of emotional impact of the client's current situation (809-910).

Felicia, a self-described feminist therapist working in private practice, noted that her appreciation of women's context influenced the way she listens to clients and questions herself. She noted that she is:

> ...always thinking, "Where could this be coming from? Does this have to do with gender roles, or messages we learn?" And you know, sometimes it's not, but I'm always asking myself these questions and they are guiding how I listen to my clients. (1133-1247)

Brian, a cognitive-behavioural therapist working in a conservative medical centre, noted that he sought to verify aspects of theory that linked gender, sexual abuse, and personality disorder. He noted: "I think you ought to look at that and know about that and you ought to very carefully, gently, ask about that, because it could be a very relevant issue..." (2090-2115)

Three participants emphasized that their appreciation of the social context of women's distress influenced the way in which they valued the information provided by clients. Victoria, a psychodynamic therapist who specializes in "women's issues" and works in private practice, noted that she would ask about and take seriously women's issues that have been invisible or seen as "silly" within the larger culture:

> I think that all the knowledge and all the things I've said to you would have an impact on the way that I would work with someone. That I would take gender seriously, that I would ask about, and look at some of what women are going through...their self-esteem, their sense of self, their hormonal changes, their economic situation.... (372-390)

Victoria went on to give another example of how her sociopolitical sensitivity would influence the questions asked during her assessment of female clients:

> ...like if a woman starts to talk about her sense of self, you know, if it's a woman who is 55 or something, I might say, "How do you feel about yourself as a woman?" So I would probably also ask questions more with a gender framework. I would then, as I said, say some of what I think [re: the impact of the social context of women's distress]. It would be no different... Mind you, I work with a lot of gay patients. I mean, I also ask things and say things about that in terms of homophobic reactions... (454-475)

For Victoria, this approach would function not only as a method of gathering information, but would model a positive reframing of women's experience.

*Avoiding victim-blame in diagnosis.* Five participants also noted that an appreciation of the sociopolitical context of women's lives influenced the manner in which they or others[2] have approached the issue of labeling or diagnosis. More specifically, participants described a pattern

of eschewing formal labels and/or emphasizing diagnoses which pertain to issues of trauma and/or abuse.

Theresa, Ellen, and Xavier described the reluctance of clinicians using a sociopolitically-informed approach to engage in formal diagnosis of clients. Although she uses DSM-IV categories for pragmatic purposes, Theresa noted that the feminist therapist colleagues at her place of work explicitly disagree with this practice (988-1001). Similarly, Ellen, a self-described feminist therapist working in a women's mental health program, noted that:

> ...there are some people who are uncomfortable with talking about certain diagnostic categories and individuals, like people with paranoid disorders or borderlines and so on and so forth. In some aspects of the feminist movement, for example, there is outrage against some of the DSM diagnostic categories... (643-743)

Ellen went on to note that although she "...used to be that kind of feminist therapist...", she no longer totally eschewed diagnosis, but did remain sensitive to the issue, particularly as it pertained to "...histrionic personality, dependent personality, self-defeating personality..." and other conditions that she believed to represent stereotypes of feminine behaviour (652-690).

Like Theresa's associates and Ellen, Xavier (a cognitive-behavioural therapist working in a private clinical health psychology setting) indicated that he was sensitive to the ways in which certain diagnostic categories have been applied to women. His appreciation of socialization issues led him to disagree with certain diagnoses as a result of the overly individualistic message they seemed to imply:

> That whole debate about that self-defeating personality disorder thing. And when you take these women...certainly there is something in their own psychology, but certainly, there is also something very, very strong socioculturally in those patterns that cause women to stay there, and to label that as a personality disorder is, to my mind, extreme. I don't want to say that it's that...to take that extreme position... (331-341)

Alternatively, other participants (e.g., Grace and Yvette) suggested that they and/or others utilizing a sociopolitical approach to women's distress would be more likely to use diagnoses that emphasized issues pertaining to abuse or oppression. For example, Yvette, a psychodynamic feminist therapist who works in a university psychological services centre, noted that she had tentatively or directly labeled situations as abuse for clients. She also speculated that some clinicians lacking an appreciation of feminist analyses of power might miss the aspect of abuse involved in some of the issues brought to therapy by female clients (765-789). Grace, an eclectic therapist working in a children' mental health setting, expressed beliefs that feminist therapists may be sensitized to issues of abuse and the sequelae of trauma and abuse. For example, she estimated that feminist therapists, who emphasize the social and political causes of women's distress, may be more likely to use labels such as dissociative identity disorder, compared with more conservative clinicians (554-562).

In sum, participants in this sample suggested that their appreciation of the social context of women's distress, including issues of sexism and gender-role socialization, led them to listen for and ask questions about gender and power, legitimize and pursue lines of questioning about women's experiences that may have been discounted within the larger culture, and to avoid certain diagnostic processes which they felt were blaming of female clients.

*Structural/Format Aspects of Therapy*

Five participants indicated that their appreciation of the social context of women's distress would lead them to be more sensitive about the structural or format aspects of therapy. Three of these participants discussed altering the times, frequency, or costs of therapy to reflect an appreciation of women's responsibilities and realities. For example, Laura, a private practice

therapist influenced by feminism and social constructionism noted that, "All of my therapy is feminist. Partly it is how you set the fee, and sensitivity to some of the structural or format aspects..." (429-431) In a similar vein, Diane, a psychodynamic clinician working in a community mental health centre, noted that:

> Women often have a more difficult time coming in because they have to take care of the babysitting arrangements. You just have a sense when you talk to the women that the children are a real consideration. They have to make the arrangements, they have to figure out how they're going to get there, and then go home from the session and get them bathed that night and be there to get them up and ready for school the next day. There are more obstacles that way. And it's not often that you have male clients saying that they can't come in to see you because they don't have a babysitter, or have to get the kids off to school, or make sure that they have their bath by a certain time, that kind of thing. So that's a little different. Women feel that it's their job to take care of these things in order to come here. And you have to appreciate and allow for that reality in your work when you hear them saying that. (776-816)

Margaret also voiced a perspective of sensitivity to women's realities and responsibilities:

> With women, there are realities that you cannot avoid, in terms of the demands on them. When we do our groups, we have to take that into consideration. You know, we don't do groups that'll interfere with getting the supper done, we don't do groups at four o'clock. We'd rather think of people with children, and the after-school rush. And even with older women, if they're of the generation where they don't have young children at home, but they may be of the generation where supper and the dishes...they and others wouldn't feel okay to leave unless it's done. So we'll do a later time. So we have to take all of that into consideration, the structural aspects of the work... (1071-1098)

Another structural variable addressed by participants pertained to the client's choice of the gender of their therapist. Ian, a psychodynamic clinician working in an in- and outpatient hospital setting (119-1218), and Steven, a systems-oriented therapist working in private practice (178-182), both noted that some female clients may feel more comfortable with a female therapist because they perceive them to have been through similar experiences and difficulties. When a

female client voices a preference for a therapist of a certain gender, these participants suggest that their requests be taken seriously:

> And if the client says, "I think this would work better for me if I saw a man or a woman...." then maybe you should trust that for a reason. Their perception is important. And I think you need to give that some attention. And these days, there's a lot of mix of male and female clinicians. It's more practically possible for them to have a choice... (Ian, 1119-1218)

As can be seen by the above excerpts, a number of participants advocated letting an appreciation of women's experiences and realities guide structural aspects of therapy, such as the fee and timing of sessions and the gender of their therapist.

*The Therapist's Way of Being Within the Clinical Relationship*

Several participants noted that their appreciation of the social context of women's distress had an impact upon the nature of the relationships they build with their clients. It also had an impact on some relationship-based interventions carried out during the therapy hour. Within the overall "Therapist's Way of Being" category were subthemes related to having an empathic connection that is based on an understanding of women's realities, the need to create a safe therapeutic relationship, and collaboration, which involved both equalizing client-therapist power differences and honouring the client's perspective. In addition, a theme which emerged less frequently was client advocacy. All of these subthemes are described below.

*Empathy.* Four participants (Diane, Laura, Nadine, and Adam) explicitly stated that they felt their perceptions of social and cultural pressures on women, such as the pressures of primary parental responsibility, role overload issues, or ideas about women's lesser power, influenced the nature of the empathic connection they fostered with clients. Asked how her self-described beliefs about role overload pressures had on her work with women, Diane noted:

> Well, I hope it gives me some empathy (laughs). I don't think that it changes the exact things I say or do. Maybe it gives me empathy. And you need that connection, because if you don't have empathy, and they don't feel empathy, then you can't have a good working relationship. Maybe in that sense, but in terms of other aspects of the approach, I don't think so. The empathy's based in that this is something very real, and there's a lot on someone's plate, and they're trying to juggle those things. (967-990)

Later, Diane suggests that her empathy may indeed influence other aspects of her interaction with clients, saying that: "It would influence how supportive you could be, and things that you would normalize or not normalize..." (1089-1139).

When asked how her self-described perspectives on women and power related to her clinical work, Laura also talked about the importance of empathy (291-389). She noted that her appreciation influenced her empathic connection with clients, and that empathy led her to focus upon the individual's needs rather than adhering to some rigid theory of adjustment or treatment. Laura also commented that she felt that clinicians who might be described as sexist in other ways often got this empathic part of the relationship right:

> Laura: I think that...I think that my practice [of therapy] is much less different [from that of other therapists, including therapists who were not feminists] than my theory. Um, I think that, you know, psychologists come from a particular theoretical background. But my sense of it is that...and my experience has been that even people who say that this is what they do very rigorously, when they actually get in a room and they look at the person, that...most of the people are a lot more reasonable. And mostly they see the individual much more clearly. As opposed to in theory, where the individual can kind of disappear. Do you know what I mean?
>
> HG: Do you mean they sort of have empathy, and that they go by what's emerging with the individual?
>
> Laura: Yeah. And they're paying attention to that and they're reasonably sensitive, and they sort of care about the person and I think that...I suspect that what a lot of psychologists who I consider to be very sexist and offensive in terms of the way they treated me in other circumstances, and/or talking to them sort of about different things, can actually be fairly sensitive to female clients, which is probably why psychologists keep having jobs. Cause I think that if we did as badly

> with people as we do in our theory, I don't think anyone would come back (laughs). So people can have very sexist attitudes and yet come in and be very warm and empathic and caring toward the client and want the best for her, and often, I think, on that level, they can have a kind of awareness about her situation that they can't really articulate or translate into theory, and that is too threatening to translate into theory. So I think that my practice is more so...I think that I do a lot more of that stuff, but I think the real difference is that I try to talk about it and I try to think about it, and I try to articulate it in the theory that I use. And what I mean by that is, in terms of getting in touch with what this person may be experiencing and what real obstacles this person may be up against. And following my connection to that, rather than holding on to that thing, "Well, this is the kind of therapy that I do." That's what you're supposed to, right?, You're supposed to have a sentence or a school of thought that says this is exactly what I do. (751-786)

Other participants (Laura, Nadine, Diane, Felicia, Adam) also noted that empathy based on an understanding of women's realities prevented therapists from pathologizing or inadvertently blaming clients. Laura was most articulate in highlighting this aspect of the importance of empathy when discussing a former client:

> HG: How do you think that your understanding of women's power influences what you do?
>
> Laura: I mean, I think, for me to give you an example of that, maybe we need to talk about this in a broader context first, because my understanding of psychology has always been that psychology says that it's all in your head. Right? An implicit message is that people can succeed in anything they choose to do and if they can't then that's somehow a problem. Because psychology has traditionally studied men, rather than men and women, and studied undergraduates, rather than people of a variety of class backgrounds, and because psychology has studied white folks, and heterosexuals. Hugely disproportionately. And for many, many years. And so, I think that so much of what people have heard in therapy is, "If you can't do this, then that's because of something you're not doing, that you should be doing..." I saw a young woman for the first time this week, and her...she's wanted to be in therapy for a while because she's been distressed. And she actually went out a few years ago and saw somebody. And Toronto's the kind of place where there is free therapy, although less and less than a few years ago with longer and longer waiting lists.
>
> HG: For a few sessions.

> Laura: Yeah, short-term. So she broke down and went to see someone in private practice. And she said that "It was an absolutely horrible experience, and I felt like I wasn't anything.". And I said, "Gee, that's really terrible. Can you tell me why you felt so negated by that?" And this is a young woman who has CFS, chronic fatigue syndrome, a history of abuse in relationships, and she is living on disability. She isn't physically able to have a job, and so she's very poor. And she went to see this woman, who charges with a sliding scale, and wanted her to pay fifty dollars an hour, and wanted to see her every week, and told her that if therapy was to work, that she would need to meet every week. And the implication that the client took home with her was that it felt like it was her fault that she couldn't afford to do that, and if she was really serious that she would find some way to get the money to do it. And it's possible, that the therapist, if she needed to do something like that, could come up with an extra two or three hundred bucks a month to do that. The fact is, though, that for this client, that would be a minor miracle. But the implication that the client took home was that it was somehow her fault. She was not sufficiently motivated to do what she needed to do. And so the client was very upset because she wanted the help, and she thought about it, and said that she thought that she could come once, maybe twice a month at that price. And the therapist grumbled about her schedule, and on how that would create problems in her schedule, and on how, if it were the case that someone came along that could afford to pay the whole fee, that she would have to see them instead. Which is a very clear message that "You're not an important person to me." And, "You're not nearly as important to me as someone who can afford to pay me well...", which is, as a therapist, not the sort of message that you should be giving to a client. And so I would say that this therapist was living in a world in which nothing existed outside her office, where she had no idea of how this client lived, and no real idea of the kind of impact she was having. (291-389)

As can be seen in the above comments, a number of participants in this sample reported that their appreciation of the sociopolitical context of women's distress led them to have empathy with their female clients, something which they viewed as central to successful therapy.

*Forming a safe, collaborative relationship.* Ten participants in the sample expressed perspectives which led to the emergence of this subtheme. The common factor underlying all of the explanations and examples offered by these participants was an effort to form safe, collaborative relationships with female clients. In order to achieve this goal, two interrelated goals had to be achieved. Forming a safe, collaborative relationship with a female client involved

both de-emphasizing the therapist's power and expert status, and its flip-side, honouring and validating the perspective and self-determination of the client.

*De-emphasizing the therapist's power.* First of all, excerpts making up this category reflected a heightened awareness of issues of interpersonal power generally, and in particular, as it related to the client-therapist relationship. Laura is an example of such a participant:

> I think that's partly where...or at least one of the places where my understanding of feminism and my understanding of society, I guess, is really helpful, because I'm aware of power. Gender issues are power issues. Issues of race are all about power. Sexual orientation issues, all about power. Issues of class. And so power is not this foreign, bizarre thing to me. Power is something that I work with every day, that I've struggled with all kinds of different forms. Personally, or professionally, or theoretically, or politically, it's all over the place and so it doesn't scare me, it doesn't intimidate me, it's something I can look at and work with..." (836-876)

Chris, who did not describe himself a feminist, and Steven, who did identify himself as influenced by feminist philosophy, reported that their sense of the sociopolitical context of women's lives led them to appreciate their impact as men within a therapeutic relationship to their female clients. Both noted that as male therapists, their knowledge of gender-related power dynamics influenced them to attempt to create a safe environment for clients. In particular, Chris, a cognitive-behavioural therapist working in a conservative clinical health psychology setting, noted that he tries to overcome a power-related gulf that can exist between clients and therapists with different backgrounds, including different genders. Talking about his female clients specifically, he said:

> Chris: For a variety of reasons, relationship issues are really important. And the details differ depending on the situation...A woman who comes in with chronic pain, I feel that I need to be real sensitive to issues of dealing in a medical system in which the predominant number of employees are women, and the men are the ones who tend to be in the administrative or treatment roles.

HG: And you have to be sensitive to a woman in that environment?

Chris: Factors that they may feel are not part of a man's normal developmental experience that might be important to them. And it's not just a male-female thing. You see the same thing, for example, with level of education, SES, level of understanding, role in the system, power. For example, how can a 50-something...I'm not that old, but I'm at a point in my life where I can't automatically assume that I can manhandle a 25-year-old woman. So how is it that this police chief who was just accused of rape [talking about a recent local news item]. How can a 50-something guy rape a 25-year-old woman? Why didn't she just beat him up? Well, the reality is that you look at the whole issue of prestige and power and how you're supposed to respond as a 25-year-old female employee of a politically powerful, psychologically charismatic guy. How was she supposed to respond to this guy's advances? I don't know whether the guy did or he didn't, but the whole issue is, that that sense of power, of ability to respond, of having sufficient...either access to the system, or to knowledge, or to believing that people will take your issues seriously...I think those are really important issues.

HG: How do you work that through when it arises? When you feel that someone, a woman, might be coming in and not telling it like it is because they feel that you can't understand, or you wouldn't appreciate it? They see you as different from them, maybe more powerful than they are.

Chris: Yes. Well, I tend to deal with it in a variety of ways. Indirectly, in a lot of respects. In terms of just the style in which I do therapy. I tend to be cognitive-behavioural in terms of setting up goal-directed treatment. But I actually spend a lot of time getting to know patients and letting them get to know me. I choose, so I'm not psychoanalytic, what I tell patients about my life, based on what I think will be helpful for them, so they get a sense of shared background. I'll choose to tell them a bit about my background based on whether or not they might be able to relate to some of it. I'm very, very, clear about confidentiality issues, always address things right up front. I am very...I work at being non-judgmental. If people think that they are risking something in revealing something to me, I try to be very attuned to that sensitivity and try not to respond with any hint of judgement or evaluation. And just work real hard to be pleasant and nice, so that even if there are things that I can't truly appreciate for not having experienced it, they at least get the sense that I want to understand it. (852-1036)

Other participants, male and female, talked about other ways of trying to equalize power dynamics between themselves and their female clients. There were many ways in which participants attempted to equalize power differences. Victoria described:

> I do ask people to call me Victoria, not Dr. X, because I think I'm trying a little to get past that power. I work out of my house, I'm not in a hospital wearing a white lab coat, so I think, it takes me...I'm thinking of things that maybe reduce it [power differential] a bit... (934-940)

Similarly, talking about herself and her colleagues at a community health centre, Margaret noted,

> I think the way we dress, too. I sure don't...I mean, I do have suits, but I'm...I think wearing suits and you know, sitting in a setting where you would have a desk, a behind the desk thing, these are all things that would be a misuse of power. like you're the one who knows... (1385-1394)

Margaret also reported that she feels a feminist approach to de-emphasizing power differences would involve asking clients not to put her on a pedestal, while at the same time using self-disclosure to model herself as someone who is not perfect but can work through difficulties. She also emphasized her attempts to avoid imposing choices on clients:

> And me reminding her, me telling her, with discretion and without details, that I have my own struggles. And I've told her some of my major difficulties that I have had in my life. Not for me, but to say, "Here you are, putting me on a pedestal...and everyone has problems...and there is hope." And some of the techniques or solutions that might have been helpful, I might say, "This has been helpful for me and others, and maybe they'll be helpful for you, too." I find that's pretty much of a feminist approach. I'm telling you what others have been through and me too and I'm not telling you what to do. Its been helpful for me, its been helpful for other women, and just look at it and see. (838-863)

Ellen discussed some of the difficulties inherent in trying to create an equal, collaborative relationship with clients.

> ...some of the principles of CBT therapy, like collaboration, the notion that the therapist and client collaborate on the goals for therapy, is pretty much a CBT principle, and it's a feminist principle as well, I think. I mean, I'm not sure that in reality it's always as collaborative as maybe it should be ideally, but at least it's an ideal, and in some kinds of therapy, it's not even an ideal. I mean, you look at classic psychodynamic, or even the thing that many psychiatrists do, essentially, which is not all that collaborative. It's oriented toward diagnosis and it's a medical model that isn't all that collaborative. It's more like, you're the patient, and I'm the expert, and I'll tell you how to fix it. I mean, I can't say that...as I say, although I'm aware of the principle, and try to pay attention to it, I have a big mouth and a lot of opinions. And, I'm not sure if what I do is as collaborative as...

> Collaboration implies uncoerced agreement and some sort of version of equality in the agreement process. And that's really subversive if you think about it in a therapy relationship. Because there are so many ways in which a therapist can be powerful. I mean, they're disclosing and you're not spilling your guts. And you've got the expert title, otherwise they wouldn't be paying you a hundred and thirty bucks an hour to see them. So you start out with certain inequalities, so to be really collaborative is a stretch. X [names another therapist she recommends that I talk to] is probably much better at it than I am. But those kinds of principles, collaboration, a genuine respect and appreciation of that person's existential reality and perspective, a collaborative, questioning inquisitive stance as opposed to a diagnostic treatment stance, some of these principles are inherently more feminist, to the extent that feminism stands for things like equalitarianism, and respect for differences and so on. (791-895)

*Honouring the client's perspective.* A second, highly related group of views within this category emphasized participants' sentiment that the client's perspective, individuality, and goals need to be honoured, and the client's efforts at self-determination need to be encouraged in the therapeutic relationship. For some participants, this honouring and supporting aspect is believed to be a corrective experience that contrasts with the lack of validation or legitimization of women's experiences and strivings that can occur in traditional gender-role socialization. Adam, a humanistic therapist working in a private practice setting, described his attempts to provide a corrective socialization experience within the therapeutic relationship:

> My issue with her is to help validate her feelings and help her validate her rights. This is because, I often find that our society doesn't validate women's feelings. It's kind of a contradiction, because women are allowed to have feelings, but as soon as you get into interpersonal situations with women or men, it's almost as if they are at a disadvantage. So on the one hand, they are allowed to express them, but on the other, these styles aren't prized in society. We tell the women that their feelings are not reasonable and they're not logical and it's silly. So, often, what we have to do in therapy, is that we first have to validate women and help them to validate themselves. And one feeling that's the largest that I think gets women in most trouble is anger. Now women can feel angry, it's okay, but they have to be really careful about how they express anger. If they don't express their anger, they get accused of letting people walk all over them. But if she expresses her anger, she's a bitch. (20-161)

In addition to creating a validating relationship, several participants, such as Margaret, Felicia, Laura, and Steven noted that paying attention to power in therapy with women involved not imposing labels or rigid models of how therapy should proceed upon women. Instead, it was the therapist's job to respect and follow the individual's judgements and goals. For example, Felicia gave the example of avoiding generalizations about what it meant to be a sexual abuse "victim" or deciding what paths therapy needed to take when working with a client with an abuse history (127-135). Laura noted that her knowledge of power in therapy and in women's lives compelled her to constantly maintain a self-reflexive attitude during her interactions with clients. She talked about her perception that an appreciation of power resulted in her needing to keep "pulling [her]self out of the client's way":

> HG: "Pull yourself out of the way?" Could you tell me more about that?
>
> Laura: Um, trying to maintain some sort of self-awareness, some sort of self-reflexivity, I guess, in terms of the assumptions I'm making, and how I understand what's happening and where the client is sitting, and what they're seeing and feeling, and continuing interrogating myself about that. (398-419)

In this way, Laura attempted to avoid becoming distanced from and disrespectful of the client's experience.

Ellen and Felicia both acknowledged that at times, it is difficult not to assume an expert role with clients. Felicia, a feminist therapist, described that her wish to honour her client's perspectives and goals sometimes clashed with her feminist values. She gave the example of working with clients with body image conflicts who endorsed values she perceived as oppressive:

> Sometimes I struggle wondering how much I should celebrate with her when she talks about feeling good for losing weight. On one hand, I don't think I would ever step on top of that and say, "You shouldn't be upset about this..." [weight]. But, then, how much do I join in with her in celebrating a thinner body, and how much do I restrain myself and not say that I wish she could have been happy last week when she was two pounds heavier. It's a constant struggle. (246-268)

Felicia went on to talk about how she dealt with clients when their goals and values did not correspond with her own:

> Well, there's different degrees to which it happens. It definitely happens because I'm never completely in agreement with all my clients' choices, but I don't think that I would be if I were a psychoanalyst, either. I think somehow there's different degrees. I don't think that it's ever happened to the degree where a client said, "My husband physically assaults me, but that's not what I want to talk about, I want to talk about how I could sort of live with it." I don't think I could do that, I don't think I could be of much help for someone like that. I would work hard to get her someone else if she wanted, but I don't think it would work with me. Because the issue would be, not the relationship, but...I don't think I've ever had a situation like that, to that degree, but certainly I've had women stay in bad relationships that I think are oppressive to them, and I've had to deal with that. And I've had to somehow convey that I respected their ability to make decisions, and also convey my own concern. I don't think it would be judgement. I would hope that it wouldn't be. But it would be concern and worry about them. That's a good question. It's a really hard struggle. (603-661)

Margaret, Laura, Felicia, Victoria, and Steven noted that their desire to honour their female clients' perspectives sometimes meant being tentative and gentle when making feminist or other kinds of interpretations of clients' issues, and letting go of or de-emphasizing such interpretations if these views were unwanted or not seen as useful by their client. Some of these participants noted that this stance encouraged women to make decisions for themselves. For example, Margaret explained:

> Well, for me, if it doesn't make sense to them [a sociopolitical interpretation], I try to find something that makes sense. I'm not here to sell any model. So what makes sense to them? For example, I'm just thinking of my mom. She's not a client, but it [a feminist outlook] wouldn't make sense to her. So I'm trying to say, "Okay, what's the problem, what's the issue?", I keep the problem in mind, and try to think about what framework would be helpful to her. What framework will be helpful to them? Like, then my job is to find another model, another perspective that would make use to them. (1404-1436)

Should an individual not find a sociopolitically guided model helpful, Margaret stated that:

> I don't know what I would say, but I may inquire, I don't know, depending.... "So how is that not helpful?" or, "What have you found helpful in your life, what way

> of seeing things?" And if I find that model to be possibly useful to them, then that's fine, yeah. If not, I would have nothing in mind... (1146-1457)

In sum, many participants in the sample described a wish to de-emphasize power differentials within the therapeutic relationship and to honour women's perspectives out of an appreciation for social contexts which have traditionally failed to honour these perspectives. Although clinicians make interpretations, including those pertaining to the social context of women's distress, they described themselves as wary of issues of power and attempted to avoid oppressing clients within the therapeutic relationship.

*Client advocacy.* Another relationship-oriented form of incorporating sociopolitical or feminist views into clinical work was serving as an advocate for clients. In contrast to the previously described attempts to de-emphasize clinicians' power, this form of incorporation requires clinicians to use their socially ascribed power on behalf of the client. Quinn, a therapist working in private practice with disadvantaged women, noted that: "I think women need a lot of advocacy" (370-397). She related that she often assists women (whom she described as disadvantaged by demands to assume primary parenting responsibility without equal access to the resources required for the job) to obtain needed social services. She also described the importance of lobbying for changes in the law to assist women with childrearing and to protect women from domestic violence (e.g., 691-728). Nadine, a cognitive-behavioural therapist working in a forensic setting, described the need for therapists to link women with community resources and to advocate on behalf of clients for the receipt of social services which will help them with parenting duties (731-754).

*Highlighting Gender and the Sociopolitical Context in Therapy*

Eighteen participants noted that their incorporation of a sociopolitical analysis in the conceptualization and treatment of female clients' distress would involve explicitly discussing or asking questions inviting clients to consider gender and its links to the broader social, cultural, and political context perceived to be related, at least in part, to their presenting problems. By linking the individual client's difficulties with broader social factors, these participants attempted to help clients reframe their perspectives on their problems.

*Degree of emphasis on gender and the sociopolitical context.* There was wide variation between participants regarding the frequency, emphasis, and directness with which such an approach was used with clients. Many, if not most participants, such as Henry (a clinician in private practice who works with couples and families), Jane (a psychodynamically-oriented clinician working in an in- and outpatient hospital setting), Zoe (a cognitive-behavioural clinician in a community mental health centre), and Diane noted that they did not perceive themselves as facilitating discussion of gender or the social context in any significant way. Talking about bringing discussion of women's social context into therapy sessions, Diane noted, "I don't think I do bring it in. Although sometimes it's definitely there in my head, as far as individual work goes, I don't, at least not in any direct way" (588-595). Later in her interview, she noted that discussion of the social context may occur only "...in passing" (596) in her work with clients. Similarly, many other participants reported that they brought discussion of the social context into therapy on an infrequent basis, such as when clients seemed particularly interested in discussing these issues (discussed below).

In contrast to this view, only a few participants such as Felicia, Quinn, and Margaret noted that a discussion of the social context played an important part in their work with women. For

example, Margaret noted that she felt discussion of the social context could often occur in her therapy sessions: "...I suppose that at some time for any woman, I've said it. I think it's an important piece of information that they need to know, that I'll explore...I think that it's very important..." (1267-1291).

Participants' examples also reflected variation in the degree to which sociopolitical issues were problematized with clients. Wendy, an eclectic clinician in private practice, for example, noted that she would tie a female client's distress to her role as an new and isolated mother, but did not emphasize a critique of society's demands on mothers as part of her approach. In contrast, Theresa reported that she would discuss the issue of patriarchy directly with clients:

> On some level, it is framed as part of a worldwide, universal struggle and I think that's very important. Its been going on for a long time. A really long time. Sometimes getting a historical perspective on that is a good idea, too. The notion that patriarchy goes back thousands and thousands of years. We are not just talking about the last ten years. (1130-1159)

Many participants reported that their degree of emphasis on the social and/or political context varied as a result of a range of philosophical, client, setting, and therapist factors. These factors will be explored in a subsequent portion of the results section. At this time, I present examples of the ways in which participants described attempting to bring the issue of the social context into therapy with female clients.

*Exploring the social context and finding your own way.* Eighteen participants noted that they would speak with clients about the social, cultural, and/or political factors perceived to be associated with the personal problems brought into therapy. When discussing this type of intervention, participants often referred to helping clients look at "external" pressures in addition to internal factors (Wendy, 169-179; also 620-633; 826-870), providing clients with a new "context" (Yvette, 576-592) or "framework" (Oliver, 328-340, 579-591), and helping them

"make links" between socialization and distress (Ellen, 217-261). Once clients had an opportunity to explore the social forces believed to partly contribute to their distress, participants described attempting to help them make their own choices within this context. Brian, a psychologist working in a conservative medical setting, who did not describe himself as a feminist therapist, and later voiced concerns about the extent to which gender and sociopolitically-based concerns should influence therapy, nonetheless described an example of how he might discuss the broader social context with a female client. In general, he described helping clients to frame the problem of depression within the larger context of the societal devaluation of traditional feminine roles, and also described helping clients to make decisions within an awareness of that context, even if this meant challenging society's views:

> Brian: If somebody comes in and says, "I really like my job as a mom who stays home,", but at the same time the person says, "I don't feel like I'm my own person...", then I'm going to have to point out that whether you like it or not, right now society doesn't afford a lot of status to women who stay at home and raise children.
>
> HG: So you're saying that you would actually bring that up in a session?
>
> Brian: I would bring it up. I'd say, "Look, I want you to understand, and it's not necessarily my view, but I'm telling you how I read what goes on out there, and part of your frustration may be...watching television. I try to put it in a context of, "This is reality as most people see it, but it doesn't mean that you have to be stuck with it, but you have to recognize its presence. If you say, "Look, I can value what I do even if other people don't...", good for you. Just so you know, if you're waiting around for the rest of society to get in line with you philosophically, you may not want to hold your breath. Because it may not happen. But, I see one of my roles as helping to be a purveyor of the reality check.
>
> HG: What do you think that would do for a woman who's at home and feeling like she was not her own person?
>
> Brian: So that makes the thing that she most fears to be true...it makes the implicit explicit. Now you can talk about it. It's not a big, dark secret any more. It's reality. But also at the same time, I say, "Look, that doesn't mean that it's not valued by you or by your children, or by other people. What you have to decide is,

what do you value? And what you value, and what other people value, and what society values, isn't always going to be the same thing..." So I say, "Look,", you know, obviously not in this brief a manner, but I would see myself in essence saying something like, "Stand up for your convictions. If you believe it's important, it is important. It doesn't matter what other people think. If you do something just because other people or society thinks it's a good idea, why are you letting that run your life?" Um, but I would also say, "You don't just blow that off and say, "Who cares what society thinks!" It's not that easy, is it?

HG: No.

Brian: And I think you've got to, you know, one of the things that would go on in therapy at that time would be...we would spend some time talking about how that daily barrage of" "Gotta have a career, gotta be a soccer mom, gotta be the CEO, and the coach of the soccer team, and bake cookies in your spare time, and keep a perfect house, and have a second career as a computer analyst, and look like a model, or God knows what...." Because that is, unfortunately, what a lot of people see every day, because that's how writers write commercials, and somebody decided that you're not somebody unless you have a career and can be a mom at the same time...Motherhood, interestingly enough, doesn't suffer in all of this. Motherhood's a good thing, but motherhood without some formal career, somehow isn't as good. "That's it? You're just a mom?" And I would spend some time trying to get past that notion, saying, "Look, just because that's what they're saying is the ideal to reach for, doesn't mean that that's what you have to have. You've got to decide what it is you want to do, what's important to you, understanding that at some level, you may be bucking the tide. That's okay. As long as you know that, you know what goes with the territory, fine." I'm working with where that person's distress is, and if it comes to light that... (tape turned over).

HG: So, you would talk about society to say, "No, society isn't set up such that you're valued, you have to decide what to do within that context?

Brian: Yes. (1303-1523)

Many other participants described bringing the sociopolitical context into therapy to help further identify and define the problems faced by clients, and by doing so, set the stage for the client to begin problem-solving. Quinn, who described herself as highly influenced by feminist theory, described this kind of motivation in talking about how she framed women's distress as a social power issue with her clients. Talking about her work with single mothers, Quinn framed

her clients' distress as partly due to a gender-based "power imbalance" that is reflected in and reinforced by women's primary parent role (89-129; 188-228). She noted that she would "absolutely" talk about the issue of power imbalance with her clients (181-188), many of whom are single mothers. Talking more concretely about bringing this into sessions, she noted: "I would try to normalize it [their distress], saying, "These are kinds of problems that many women come in here with, and it's an issue that is very common amongst women because the men go off..." (243-250). Quinn noted that she would take this stance because it would set the stage for a woman to begin problem-solving within those set of circumstances:

> The reason I frame it in that way is because there's something we can do with that. We can teach women ways of looking at their situation so that they can take some kind of control over their lives. Implement some strategies to help them balance themselves better, so that they don't end up so thinly stretched that they are undermining their own health physically and psychologically. (138-148)

Quinn went on to clarify that she does not necessarily incorporate a sociopolitical analysis in therapy to encourage women to equalize power differences, which may be unrealistic in an individual's circumstances:

> ...by framing it that way, you can teach certain skills and abilities to help women make better choices. A little better in terms of themselves....not better choices in terms of how to get power back to them, but better choices about how to take some control in their own lives. Considering the situation that they're in, what's the best possible expectation, and how are you going to go about pursuing that now? That's how I see it. (168-179)

Grace also described how she brought the social into therapy to help frame and define problems and present them as issues to be further explored and solved:

> You asked me where does the distress come from. For sure, there is, at least we can say, habitual ways of relating to the world that develop, for sure we could start there. And then, we can look at the current stress around the person, and certainly, for many women, there's a heck of a lot of stress these days. Certainly for men, too, but women do have unique stressors. Very often, the whole idea of supermom, you know, having the career, being all these things that you have to be.

So you can look at the social context. And, like, I don't think I'm a radical person at all, but I certainly do talk to women about the messages that we get from society, that even if they aren't put on the table in a direct way, they're always there in an indirect way. Like our mothers teach us to take care of people without saying, "Take care of people!", and those sorts of things. So I talk about that kind of thing directly.

HG: Can you give me an example of how you've done that?

Grace: Well, I probably do it a real lot because I think that part of what we do as therapists, we help people to test reality. And I think that these pressures and messages are a reality, so I put it on the table as a reality. "This is how we were raised!" And what women invariably say is, "You know, you're right!" But that's not how they were kind of framing their life. So I guess it's another frame, I guess.

HG: They tend not to see that coming in?

Grace: Oh, very often they think that you are brilliant when you point this out to them (laughs). They think you've just summed a lot right up. I mean, if you used that "imposter phenomenon" idea that I talked about earlier, and this idea of how women are raised, you know, learning all these things through osmosis, I mean, they think that you are the most brilliant therapist in the world (laughs). So anyway, how have I talked about that with my patients? The societal context thing?

HG: Yes.

Grace: Well, I guess that I do it just like I'm talking to you now. Say someone's talking to me about a relationship issue, I might say, "You know what? It seems to me that you're really worried about taking care of this person and I'm thinking to myself that maybe we need to look at that. "You know, women are often raised to..." and then I'd go through my spiel, and then they would go, "You know, that's exactly it!" And at that point, I'd say, "Well now, let's look at this, though. Is this how you want to be with this person, or is there perhaps another way that you could choose to be with this person?" That might be a way I'd take it.

HG: So they'd know what the expectations are, but then they'd be able to decide if it was for them?

Grace: Yes, exactly. What the costs might be for them. So I think my job is to make these things clearer in this way and still up to the client to choose. I feel that I help frame it (372-479)

*Normalizing, legitimizing, and de-pathologizing.* Many participants (e.g., Quinn, Paula, Felicia, Margaret, Oliver, Victoria, Theresa, Yvette, and Ellen) also emphasized that bringing the social and political context of women's lives into therapy is done for the purpose of normalizing client's concerns, helping them feel understood and less alone and defective. This is in fact a form of diagnosis. Felicia, a feminist therapist working within a women's mental health program, illustrated this in her discussion of working with a client with poor body image:

> I certainly like to, as much as possible, have my clients understand that this is not only about them. It is about them, right, but it's not only about them and in many cases, any woman in the same situation might experience the same pressures and stresses, and many women do. So I work very hard to broaden the perspective and help women understand that it's not only about their flaws and deficiencies and problems, but it really is such a setup in society. It's none of those things, "I'm not strong enough", "I'm not smart enough", "Why can't I feel good about my body?", and all those things. And of course you don't feel very good about your body, you're taught not to feel very good about your body. You've learned your lesson well, and so have your friends, even if they're not really talking about it. You know, and then, you might talk about eating disorders, and the shame that women have in their bodies... (826-870)

Felicia went on to say:

> And so I'll start off that this person has a problem with body image, and it'll stay there, too. I think as a therapist, it's important to understand all the individual, emotional experience and meaning, but, I certainly feel that it can't stay in that individual place, we've got to look outside and that's where a lot of my work focuses. I think that it's really important to help this individual woman feel like, "Oh my goodness, maybe this isn't my struggle alone." (871-982)

Margaret also voiced a wish to give clients a context which helped them feel less alone and defective. She also described using this as the starting point for encouraging women to take hold of the power available to them:

> I mean, it's part of what I tell women at times in private counseling, because I find that in private counseling, working with women, is that a lot of it is giving them that information, so there's an education piece. Like a teacher giving them information about it. So, a lot of times, yeah, thinking about power helps because reminding women of the messages they got, sometimes it helps to say, "No

> wonder you feel that way; it's not because you are defective; it's because you're kind of trained to feel that way." So, in a way, you're encouraging them to be more self-empowered: "So what do YOU want?" As opposed to...The other day, I did a forty minute crisis walk-in, and I might never see this person again. Young, very young to be where she was at. At a high post, well educated, well dressed, about to be married to a doctor. And she was saying a lot of, "I should feel this and I should feel that, and my friends say that, and my husband to be says that I should..." And it struck me and I said, "What about you?" "What about you?" And I said, "You're in major distress, and you're not crazy." And I said, "In all of my years, I've never seen a crazy person," and "What about you?" So the "What about you?", to me, is about power. What about your own power, what about who you are? In discovering yourself...that's where the power starts. So I find that power is a big part of it. In terms of the reading we get from the outside, the message we get as women is, you're not the one in power. But also, the answer is to discover myself and find my own power, too.
>
> HG: I'm not sure what you mean. Is your answer that: "You're not in charge", or whatever, and so women don't know what they want? Because, like you said, you're not trained to know...
>
> Margaret: Yes. They often aren't trained to know that they even have a right to their own drummer.
>
> HG: So part of your job is...you said, "educate"?
>
> Margaret: Yes, give them a context: "What did you hear at home, what did you hear at school, flipping magazines. What were the messages you got, what were the role models you got? I think for every woman...I don't say things like that if it's out of context to what we're working on and not needed, but I suppose that at some time for any woman, I've said it. I think it's an important piece of information that they need to know. That I'll explore. But it's not something that I have to repeat in every session. But I'd say that it's important in the sense that if I don't make sure that that piece is known, like, if I don't check that they know it, and if I don't go, if I don't remind them if they need it, even if I have to remind them once or I have to repeat it a whole lot, um...I think that it's very important, because otherwise, there is a risk that they will continue self-blaming. (1169-1291)

Victoria notes that for her, consciousness-raising helps to honour the client's experience by identifying their problems as legitimate ones:

> I think that I would directly, obviously say things, okay? I would directly say things about the things I've just said to you [about society not valuing women's experience, pressures on women to meet unrealistic ideals of appearance, etc.], about "Men and women do have different experiences." I would say it right out. I

> would say something about the research, because I spent years as a professor and I could quote research findings. So, I think that compared to someone else who did not have my point of view, I would say it right out. And in doing that, I would be normalizing it, addressing it, identifying it as something legitimate, you know? (442-454)

Oliver noted that by "connecting the emotions to the broader context, and legitimizing that emotion, you then also provide a framework for her to validate her own experience." (328-340) Oliver described how he brought issues of the social context into therapy to help a client understand and orient her distress and make her own decisions:

> HG: What did you mean by...you used the expression "connecting the affect that's there with the larger context"?
>
> Oliver: Well, that's a good question, because there are really two parts of it. One is the immediate context of her own experience at work [Oliver had been discussing his work with a client who was distressed about experiencing a "glass ceiling" at her place of employment], that is, recognizing that there are not just one or two little events, or even one or two big events, but an undercurrent. A many-year, accrued experience between her and this organizational culture. So that the emotions she's experiencing are not just a response to this having been passed up for a promotion, but it's something that's been there for a long time, stewing and brewing...The second part of the context then is a broader set of social norms. That is, what is it like for a woman of her...she's approximately 50. So, what are the social norms for the great majority of women of her generation, vis-a-vis being a professional person, being part of a process that changes what the norms are. And there's a recognition that the norms today aren't what they were when she started off 25 years ago. But, nonetheless, in the particular setting in which she finds herself, and I can't divulge more by giving details, but X is not such a huge place, that, particularly when you work in relatively large systems, that, if you're reasonably alert to how the community functions and know something about the community, you know which organizations have the reputation for perhaps being more progressive, and which have the reputation for being...I don't want to call them outright reactionary, but which might be more traditional, for whom novel approaches, be they for men or for women, would be a more difficult thing to allow and absorb into the system. And this particular system, which at the very least could be described as small c conservative and traditional in its organizational style and its administration and its management...
>
> HG: So part of what you're looking at, then, is what her experience is of being a woman in this particular culture.

Oliver: Yes, sure, that's right. And how it contrasts with the very small number of women who have succeeded to the very highest level. They tend to be characterized as women who try to be more like a man than a man, kind of notion. And this...person I'm working with has a very strong set of personal values, and one of her dilemmas is how does she retain her own values and can she retain her own values, and make it to that next level, and is it a trade-off? Is it a matter of, she needs to say to herself, "I'm making an active choice here, and in choosing to be the person I choose to be, that may very well preclude that kind of advancement."

HG: So she's thinking about who she is and how she fits in, and what some of the costs are...and what she's willing to put up with...

Oliver: Yes, and what she's not prepared to do. And the approach I'm using with her is partly, legitimizing, to enable her to explicitly identify what her own values are, what her own bottom lines are, where there is room to be in a grey zone, to compromise, and where, when it goes beyond a certain point, that's no longer a compromise, that's losing who she is.

HG: So it sounds to me that the philosophy or the goals of therapy...please correct me if I'm wrong, at least for her are to...I don't know whether with women generally, this is what your role is..but, to be someone who validates and legitimizes and helps someone explore...their experience.

Oliver: I think at the validation level, the approach I bring in is more activist. Because it involves bringing in information, on things like social norms, even though she may be aware of them. And I'm saying "she" meaning not just her, but "she" generically. Sometimes I think it's important to remind people of things they may already know, and sometimes it really is new information. So I see myself as someone who needs to bring in, in the sense of validation, our experience, in a social norm sense or a social learning sense, and how it fits in... (359:523)

HG: Do you mean that you might ask them to consider the social context of being a woman if it seems to be relevant to what you're hearing?

Oliver: Yes. Absolutely. (602-748)

This type of normalizing is in fact a form of diagnosis, although it differs from the process of offering formal DSM-IV types of diagnoses in its emphasis on framing women's responses as normal and not pathological.

*Synthesizing multiple levels of explanation.* All participants who described discussing social issues with clients also noted that this discussion was accompanied by an exploration of multiple factors involved in the client's problem. For example, Yvette noted that she explored both intrapsychic and familial factors and tied them in with social ones to help her client reach an understanding of her difficulties and options:

> I also was interested in understanding how her early relationships with her parents and others would have contributed to her sense of self or her self concept, and what her understanding of that, and the social conditions under which she grew up. She is a little bit older than myself, and seems to have had...despite not being that old, seems to have been fairly influenced by a rather traditional understanding about what a woman's duty is in terms of her husband and children and community at large, and so, its been interesting from that point of view to bring together all those different factors...the familial factors, and also the sort of social conditions and the expectations in which she was raised, that affected the ones that she would have for herself and what she would allow herself... (150-175)

Oliver also emphasized the importance of looking at the relationship between the social and the individual psychology of the individual. In discussing how he talked with women about the role of the social context of their difficulties, he described how intrapsychic and social factors may interact and this needs to be explored:

> I'm always alert to the underlying affect attached to any of those kind of issues. What the meaning and the experience of that is. I think that one of the phenomena for more junior clinicians to get a handle on is how difficult it is for people to give up that which seems so painful. But it's also associated with other kinds of benefit or gain. So, the same kinds of problems that limit the person, by virtue of gender, may also be kinds of behaviour that has also given them a certain amount of reinforcement that helps them sustain and maintain behaviour, even though it doesn't seem very helpful to where they want to get.
>
> HG: Right. So, would I be characterizing that correctly if I was to say that the training women get to be "good girls", in a traditionally feminine sense, can be very...can stand in your way, but on the other hand, it greases certain wheels?
>
> Oliver: That's right. Yes. And the issue from where I sit, in the chair that I sit in is not to convince a person that they have to be a different person, but it's to help them first of all, acquire a sufficient grasp, through information, or assisting them

> with recognizing how they think, recognizing how they feel, so that they're in a position to make choices. So I see myself as facilitating an active decision-making process. So that if it's a woman who is perhaps never having thought about it that way fully, but who is struggling between being a contemporary professional woman on the one hand, and yet feeling that she's supposed to be a traditionally feminine woman on the other hand, is to get some grasp, in both a developmental context, in terms of the social context, of what are the ingredients that are involved in that dilemma, that are playing a role in creating that distress. And what we do then is mobilize the person's resources, internal and broader resources, so that they're in a better position to take charge and make active decisions for themselves and see that through. If it turns out that there are impediments to that, then that's where I bring out either the cognitive or psychodynamic background, or both. (602-748)

In this way, participants described exploring intrapsychic and other issues in addition to social factors, in order to put together a full picture of the individual's difficulties which could lead to a wide range of interventions and solutions.

*Exploring the social repercussions of different solutions.* In addition to exploring the relationship between social factors and the emergence and maintenance of women's distress, a few participants (Laura, Paula, Yvette, and Zoe) emphasized the need to consider the social repercussions of various solutions to clients' problems. For example, Laura and Zoe noted that it was potentially detrimental to clients to assume that certain solutions to problems, such as increasing women's assertiveness, would benefit clients in all situations, because there could be negative social repercussions to women for various actions seen as incongruent with a female role. These participants described discussing the social repercussions of various therapy solutions with clients:

> HG: [clarifying an earlier statement] So rather than just having the assumption that they should assert themselves, the context influences what the 'right' directions could be...?
>
> Laura: Yes...

> HG: And how are different actions going to be accepted, and how will you deal with that reality?
>
> Laura: Yes. And what do you do about the fact that women can say less than men and yet be perceived as freaking out, and getting out of line, and all that? (477-493)

Yvette, a feminist therapist discussing her work with a client in an abusive marriage, stated similar concerns:

> And so I've found that what I've done is tried to take what I know about relational models of therapy and contextualize them. And so, with this client, we've worked a lot on her individual circumstances, but we've tried to put them in a broader context of how women are socialized, and how men are socialized, how that translates into how she was socialized. Also...what...sort of context she would be dealing with if she was seeking to divorce, so that she could be armed with information to hopefully, make her situation better if that was the route she decided to take. (572-592)

Similar, Zoe, an eclectic therapist working in a community mental health centre, noted that she has individualized and modified her approach to working with violence against women to involve discussions of cultural values that have been important to native clients she has served (20-50).

Using a variety of media and methods. A few participants also described using a variety of media and methods to help clients explore the social context of their difficulties. For example, Ellen noted that she has recommended literature to clients. Talking about an "archetypal" female client experiencing "severe burnout" due to role overload, she noted:

> ...she had been raised to be overly compliant, overly responsible, obedient. She was oversocialized, in many ways. And one of the first things I gave her to read, early on, was the book, "Too Good For Her Own Good", have you seen that one? It's an interesting book by Claudia Bepko, and it talks about how women are socialized to be morally good, be high performers, take a lot of responsibility for others, never complain, be overly responsible, not meet their own needs. So that was a good, interesting book for her to read. (67-128)

Paula, an eclectic therapist working in private and family/children's mental health settings, noted that she has encouraged female clients to read books and watch films. Talking about women's hesitancy to make changes in their lives and become more assertive, she noted:

> Maybe they're afraid to move on to the next step. And maybe they're afraid that, and this is really common amongst women, "If I make changes in my life...because my thinking is so different from theirs, I don't know if I can do that. I would lose their support. I would lose everything..." I often give them the video, "Educating Rita", because just like them, Rita has to deal with that, and she makes the choice to move on, but other people in her life don't. And "Shirley Valentine". I use videos and books about women in a similar situation like that. (971-988)

Steven noted that he has sometimes used the therapeutic relationship as a means of bringing gender issues into relief and discussing them. More specifically, he related that he sometimes finds it useful to use his status as a male to encourage discussions of gender and male-female relationships with female clients. Saying that he perceives all of his female clients have feelings about what it is like to be female in a man's world, he noted:

> ...the most important part of it [with a woman, working with a male therapist] is to create an absolutely safe therapeutic experience. And then sometimes, my being male is extremely useful. Because if they can feel secure enough, they can then deal with their issues with men with me...there's the transferential stuff, because it provides an opportunity to get at all of that stuff...One of the things I find is when women get secure enough, almost all of them have issues about seeing a male therapist. Gender is ever-present. It's always there. So for any woman seeing a male therapist, gender is going to be an issue. For some, it's larger, particularly if there have been issues such as sexual abuse, but probably, it's a selective sample because they are clients...but probably, every woman has had some experience that they have carried with them. Maybe not every single woman, but many of them, so that at some point in their lives, they have had some experience that felt like sexual pressure or harassment or rape or some variation on that. If it wasn't overt, it was strong enough so that it left them with a lot of feelings of... And so, everyone who comes into therapy, every women who comes into therapy has some issue around men and what it's like to be in the world with this other gender, you know. And even if nothing overt has happened, they are exposed to the media, and have body image issues, and all that is just in there and it's just part of what they and I deal with. (188-231)

In this way, Steven's gender is beneficial because the relationship can serve as a catalyst and forum for the examination of gender issues that related, in some ways, to female clients' concerns and difficulties.

The above examples suggest that participants had a variety of methods and manners by which they engaged clients in an exploration of issues of gender and the social context. These approaches included books, movies, and examining client-therapist interactions within the context of the therapy experience.

*Teaching or inviting.* An important distinction to make in participants' descriptions of bringing the social context into therapy involves the degree to which participants were didactic or inviting in their approaches. Many of the above participants explicitly stated that they were didactic or educational in their approach. For example, as noted earlier, Margaret stated that ...there's an education piece. Like a teacher giving information about it..." (1170-1190). Jane also noted that she has sometimes assumed a didactic role:

> With this young woman I was describing with an eating disorder, with that kind of issue, where I thought it was more driven by social forces that operate against women, I did a lot more educating, and you know, talking to her about the effects of these things. You know, the advertising and models and all that... (484-506)

Some participants also described assuming a more inviting or questioning stance regarding the issue of the social context and its relationship to clients' distress (Yvette, Theresa, Felicia, Oliver, Steven, and Ellen). In taking an inviting stance, Felicia emphasized the importance of asking clients questions to facilitate their thinking about gender-based assumptions they may have never considered before. According to Felicia, this process often opens up new choices for clients, who become more aware of their own unquestioned assumptions and changing preferences:

> Well you know, I don't feel I've done a good job as a feminist therapist if I don't comment, in some way, or maybe not comment, but if I don't raise questions. So I

> think for me, it's mostly about raising people's curiosities. But if someone is sitting across from me an is saying something like, you know, for example, "It's really good that I made the decision to stay home with the kids, and my husband really doesn't want me to work, and I'm happy staying home, but I get depressed sometimes..." Then I might want to work with her emotions, you know, there's a whole bunch of them there, and as a therapist, I think it's important to see all of the emotions, to see which ones are there, and work with that. And at some point, I think that it would be important to show her my curiousity about, "How did you come to that decision that it would be you that stayed home with the kids? How did that decision get made? And to begin a process of questioning all the assumptions that we all have, that my client would have. It's really beginning a process of saying, "How did that happen? How did I land here? And when I say that I'm happy, how does that fit with the depression that I feel?" It's really about me raising questions and raising awareness. It's not about me saying, "Your husband's oppressing you!" "Society's oppressing you!" It's not about doing that. So I think that that's mostly how I do it. I ask them questions, and when you ask questions, new possibilities emerge. And it's difficult. I mean, sometimes it's easier to think that this is simply my role. Ignorance is bliss. Sometimes it's more complex and difficult to say, "Maybe this isn't my role! Maybe this isn't what I want, and then what do I do? How do I deal with this?" So it's actually very difficult work, I think, in terms of then you work with them to decide for themselves about what do I want now, now that I see I have more options. And maybe I'll want the thing I had before, but it needs to be a choice... (483-589)

Theresa noted that her manner of inviting and questioning involves encouraging women to talk to one another about their experiences:

> HG: ...what questions would you use to explore the larger social context?
>
> Theresa: You'd ask them to explore what they're experiencing now, and I would use questions that would invite them to explore their experiences with other women, so I think this social context is very important with other persons in their world. You invite them to go out and interact with people and make those contacts and explore the context in the here and now. For them to get a larger sense of what's going on with other people other than themselves. I think it is very important for women to talk to women. In the past, that's what didn't happen. So women need to explore their...With men as well, but I think that women connecting with other women is a very important part of this... (200-218)

When asked how this would help women, Theresa noted that:

> It helps them to understand that their thoughts and concerns and struggles aren't just uniquely theirs. It helps them to explore new contexts, and maybe just to look at things differently. So that they just don't feel it's just them, and so they don't

> just accept the...the more traditional, culturally determined explanations of their lives and what's happening to them. We need to get them to explore other perspectives. (220-231)

As can be seen by the above examples, sociopolitical factors in women's distress can be brought into the therapy session in both didactic and inviting, exploratory manners.

*Resolving Intrapsychic Conflicts Associated with Gender and Power*

Five participants (Oliver, Felicia, Theresa, Steven, and Yvette) described engaging clients in psychodynamic, emotion-focused, or humanistically-oriented techniques to help female clients resolve internal emotional splits or conflicts that were associated with gender-related societal pressures. For example, Theresa described how she helped a client work through conflicting feelings about assertiveness:

> ...she will come in, and there will be part of her that...her thoughts and feelings, that go very much in line with a traditional view [of women's place/appropriate behaviour]. So there's part of her telling her to shut down. And there's another part of her saying, "This doesn't feel good." And I think, rather than just didactically teaching her about that, working with both of those parts is very helpful. It would be helpful to bring both of those sides into relief, and as she becomes more aware that there's a part of her that feels that that doesn't really feel good, sometimes it helps to do some reading or to connect with other women at that point... (295-320)

The above example also indicates how this sociopolitically-guided technique can be combined with a consciousness-raising approach.

Similar to Theresa's example of exploring and defining client's internal conflicts, Yvette also gave an example of using an emotion-focused integration approach to help a client work through a socially based internal conflict:

> The other thing I did was find ways to encourage her to allow herself to identify her needs and to find ways of expressing them. Technically, what that involved...one example of that would be she felt a split within herself between the

> side of herself that was "bad" and "selfish" and wanted things and wanted her needs met and another side of herself that was compliant and accommodating and "nice" and invisible. I did two-chair exploration to facilitate her exploration of those two sides of herself. It was like a learning exercise.
>
> HG: Those two sides talking to one another?
>
> Yvette: Yes, in fact, I sort of started her off talking from one of those positions and fleshing it out and asking her some questions just to get at what does this self-concept contain inside. Then I had her talk from the other side that emerged, and then had the two sides talk to each other. And she's the kind of client, we did that in one session and three sessions later she was talking about feeling more integrated. And feeling more a sense of understanding that this side that she had labeled as bad and needy was really expressing things that were really legitimate things about herself. She was working on integrating these things. (241-281)

Felicia described working with eating disordered clients to understand and resolve conflicts related to oppressive pressures regarding weight and appearance:

> It's a struggle. She really wants to take pride in her body, and own it no matter what she looks like, and yet there is the reality that she feels more attractive when she's thinner, she gets, of course, as a female in an oppressive environment, she gets more attention when she's thinner, and it's...you know, following her one week as she feels good about losing weight, and working with her on how she feels about that, and then seeing her another week, when she say, "Why do I have to lose weight anyhow?" And so, I'm really aware of what it means to feel good about your body and what it also means to feel oppressed about it by society and I'm trying to work with her in integrating those realities. These are some of the issues that have come up with her and have not been so dissimilar from my work with many other women. (197-239)

Felicia later went on to describe more about how she helps clients in this way:

> Probably, in every woman, there is that ambivalence. And I think I look for it, that ambivalence. I mean, the celebration that she feels, and all the things she had to do to get to a thinner place. And so I think I would look for that, too, not deny those aspects of the situation.
>
> HG: Is it making the ambivalence more visible?
>
> Felicia: Yes. Exactly. I think that's a really good way of putting it. Yes. So I think I see it and I say, "Let's put it on the table." It doesn't mean that we don't have to celebrate a thinner body, but it does mean that we have to look at the bigger picture and make sure that this truly feels good for you.

> HG: Cause you go back and forth, happy because you're celebrating by society's standards, but sometimes realizing, God, it really costs you.
>
> Felicia: Exactly. It's difficult for her, for me, and it's an ongoing struggle. The integration is a moving goal. It's never really integrated fully, but it's a process of being alert and aware of these ambiguities and the process that you go through... (288-330)

Working from a more psychodynamic model, Steven described working with a female client whose difficulties came to be understood as partly influenced by issues of gender and power. Describing a client with a history of sexual abuse, who pursued numerous extramarital affairs, he explained:

> ...as soon as the affair matures a little, she loses interest. Her interest is in the pursuit phase. Her story is that, and her family knows about the abuse, and their take on it is that...there are a number of messages that indicate something like, the implication is, "You asked for it." Her take on being a woman seems to be related to a number of factors that her sexuality opens doors for her, and she uses that a little bit, but also is very suspicious and angry about it, and unhappy. It's both something that she counts on, and something that she's unhappy with as well. So she knows that if she goes to a job interview and is a little flirty, she has a good chance to get the job, which, on the one hand, she is glad to get, and on the other, it makes her angry. She knows intuitively that if she were ugly, or unattractive, she might go through a much more rigorous process. But if some guy sees her and goes, "You're attractive..." And so she has a lot of feelings about this process, and in a way is pretty disconnected from her own sexuality, because it's always there in the service of a male. So that's her perception of what women are sexual for. I think her affairs are one way of trying to master this. It's not the best way in the long run, but it's her way of saying, "I'm in charge. I'm going to be sexual for me, not for some guy. I'm the one who's going to pursue this. I'm not going to be a passive object..." That's the example of a client for whom issues about gender are huge, and in all kinds of ways, not just about the incest, but all the other issues. About what it's like to be a woman and how you are treated by men, and in the way that sexuality is defined for her in terms of others rather than by and for herself... (58-126)

After working together to understand the client's conflicts in this manner, Steven and his client then discussed alternative ways in which the client could address her concerns in ways that were more acceptable and helpful to her.

*Going Beyond Gender Role Socialization: Learning New Skills and Attitudes*

Another subtheme comprising the major theme of "Incorporating a Sociopolitical Analysis..." pertained to therapists' attempts to help female clients learn new skills not perceived to have been reinforced by gender-role socialization and gender-related social norms and expectations. Several participants in the sample explicitly talked about helping women overcome skills deficits that were associated with their traditional female gender-role socialization. In each of the examples below, participants indicated that they attempted to discuss behavioural options with clients that went beyond the traditional gender roles perceived to be constraining and distressing them. Wendy related how her feminist perspective led her to intervene in this manner, and gave a hypothetical example of what this might look like:

> Wendy: I would like to think that it [my exposure to feminism] has...helped me to help women to think of their options as widely as possible. I mean, I don't think it's my goal to get every woman out there working for a living. That's not it. But to help women, and men, to look at their options as broadly as they can and not be caught up in traditional views about what men and women can do. I don't know if I can give you an example, but one might be, a man whose wife is expecting a baby, might not consider that he might take six months off to stay home with the child. Not necessarily that that is what the client chooses, but it should be an option for him to think about, and for him and his partner to decide whether this is an option or whether this might be the best option for them. That would be, I suppose, the kind of thing I would do.
>
> HG: So you would encourage them to look at the broadest range of options possible.
>
> Wendy: Yes, so that they did not feel limited to one way. (644-684)

Similarly, Laura noted that she would encourage women to think beyond gender-related rules for behaviour. Talking about how she would intervene with a female client in problem-solving, she suggested:

> Laura: And sometimes that's an interesting question: "Well, what if you were male?", right? Or, "What about your best male friend, what would he do?" And

> then, often, that leads to, "Well, he'd do something different." "Okay, well, why is that, and would that be a good thing for you to be doing?"
>
> HG: So...you would actually ask that as a question?
>
> Laura: Uh huh.
>
> HG: To...what? Open up options?
>
> Laura: To open up other possibilities. And again, just to try and think about things. So much about what keeps people trapped is, partly habit, and partly, "I have no idea how to do anything else. This is a well-worn path." "Well lots of people do lots of different things! What can I see myself doing that I can try?" (566-589)

Other participants (Diane, Margaret, Ellen, Paula, and Adam) noted that they would directly and explicitly encourage female clients to further develop self-care and assertiveness skills, which they saw as not adequately reinforced in women's upbringing, and which two of them tied to notions of women's lesser status relative to men. Diane noted that her approach might involve helping a female client to say no to pressures to "have it all" (990-996). Ellen noted that:

> I certainly encourage my female clients and sometimes my male clients to do things like say what they want, ask for what they want to get, to speak up, to take responsibility for taking care of themselves rather than waiting for somebody else to do it, to put themselves higher on their priority list of things to do. And I'm pleased with my female clients when they come in and tell me that they are better at taking care of themselves in this way. And so that's a fairly overt expectation or organizing principle. (878-895)

Similarly, Paula noted that with her female clients with issues of assertiveness:

> Paula: It's often that I find I have to do some restructuring, because there are often thinking errors. Society-driven thinking errors that are so implanted that they have a hard time understanding what their rights are. And not their rights in an outrageous way. Their rights as human beings, you know. I'm one of those counselors who still uses that book, "Your Perfect Right", which was the first little book on assertiveness. It's still very relevant for the women I see. (417-473)
>
> HG: What kind of things have they internalized? You mentioned fears about hurting others, and confrontation...

> Paula: Yes, and putting themselves last. Not asking for what they want. Expecting other people to know, and if they don't, getting angry with them. Especially husbands. They'll say, "He didn't offer to do this..." "Well how should he know?" And they'll say, "Well, this and this and this..." And I'll say, "Okay, let's work through this and really put it on a concrete level." Getting it so you're helping them see that they have the right to ask. Helping them understand that someone saying no to them isn't the end of the world. Helping them look at how many times they hurt themselves trying to protect themselves from rejection. They'll go through this whole elaborate procedure to avoid someone saying no to or rejecting them. Positioning. And I think that's something women are taught from a very young age. Protecting other people's self-esteem and feelings, and doing things indirectly, and manipulating sometimes, too. And being resentful when no one notices that you've put in all that effort, and that they don't know why you might be shunning them, not talking to them now. Being direct is very difficult. I try to help them feel it's appropriate to want something. The hardest thing for women is often around sexual issues. The hardest thing to ask for is a more extensive, creative sexual relationship. That seems to be really ingrained that that's not appropriate. (417-473, 641-649)

In this section, I emphasized examples of participants who explicitly described goals of countering women's gender-role socialization and encouraging the development of new skills such as assertiveness. However, the conceptualization of this category can be expanded further. For example, clinicians who create validating relationships within which women's perspectives are honoured may be thought of as providing new experiences that help to counter gender role socialization. Several of the consciousness-raising examples described earlier also contain a resocializing impulse. In his earlier example of working with a depressed homemaker, for example, when Brian encouraged his client to consider whether she valued her role (even if society did not), this opened options for his client to resist the devaluation of women's roles in larger society. Victoria's manner of asking about and honouring women's experiences that are traditionally marginalized may also be thought to encourage a positive reframing that goes against dominant ways of seeing these things. Similarly, Margaret's encouragement to her client to consider "What about you?" and take her own power into her hands may also be thought to help

her client free herself from putting others before herself. In sum, many participants' knowledge of the social and political context of women's distress led them to encourage female and male clients to consider ways of thinking and developing skills that went beyond constraining, traditional gender roles for appropriate behaviour.

*Beyond Traditional Psychotherapy*

A few clinicians in the sample noted that they also advocated approaches which fell outside the traditional therapy format. Steven suggested that clinicians could suggest courses or groups that clients might wish to take part in concurrently but separately from their therapy experience (595-604; 676-693). Margaret talked about serving as a facilitator or sounding board for women's empowerment groups that were run by the women themselves (59-62). Finally, Ellen, Felicia, Quinn, and Steven talked about the importance of being socially active outside of work in order to advocate for social change. For example, Steven noted:

> Right now I'm involved in a group of people and we are trying to see if we can create something, just looking at how we can get genders together in a broader social context. I don't know what we're going to do yet, but it's very interesting. I am the only psychologist involved. We're trying to mobilize a few people and what we are interested in is doing an outreach thing to get people in the community talking about stuff, how to change gender relations and power and how to change that. My feeling is that I do it all the time in couples therapy, but I would like to do something rather than just therapy. Just as we were talking earlier, do the educational part, not just the therapy part. How do you get people exploring this stuff on a societal level, so that these questions become part of their social consciousness and can men start to think about how their period of...sort of training as boys and men have affected the way they behave and [tape unclear] is there a way for us to talk about that together, rather than just separately? Not just men go to men's groups and women go to women's groups, in which everybody says, "We're the good guys, they are the bad guys..." (1100-1144)

The above examples suggest that psychologists with an interest in gender and gender-related social and power issues sometimes also engaged in activities that extend beyond their work within

the therapy hour. These activities, while not considered therapy itself, were seen as activities which could assist and empower clients experiencing problems that were perceived to be partly related to being female within a disempowering social context.

### *Summary of Participants' Endorsement of Incorporation Techniques*

Techniques or approaches guided by a sociopolitical analysis of women's distress emerged in the semi-structured interviews of eighteen out of twenty-five participants. While thoughts of subversive and overtly political consciousness-raising techniques may frequently come to mind when many think about therapy that includes a sociopolitical approach, the results of the present study suggest that there are actually a wide range of ways and levels at which clinicians can take sociopolitical factors into account in their clinical work with women. Ten participants in this study indicated that their perspective that women face some form of disadvantage in our culture would change the way they conducted assessments, five indicated that it would influence the way in which the structural issues of therapy were negotiated with clients, and eighteen noted that it would affect their attitudes and goals within the context of the therapeutic relationship. Eighteen participants revealed that they would discuss social, cultural, and political issues in therapy with women, although the importance placed upon this discussion varied widely and appeared to be central to only a small subset (approximately four participants) in this sample. Five clinicians described helping clients work through emotional conflicts which were integrally related to women's oppression, while several described assisting women with developing skills to correct deficits resulting from socialization practices which have disadvantaged women. Finally, five participants described techniques, including encouraging social action or consciousness-raising outside of therapy, which fall outside of the realm of traditional therapy practice.

The techniques described above may be thought of as roughly divided between two groups. The first group consisted of therapy process approaches which are guided at a background level by an appreciation of women's sociopolitical context, while the second group involved techniques which emphasized women's issues as the appropriate content of therapist-client discussion. The former group of techniques tend to focus on relationship and structural/format issues, but could also apply to techniques aimed at helping clients resolve internal conflicts related to issues of gender and power. These techniques may not appear to be overtly political or feminist. The second group involved consciousness-raising, either didactic or inviting, which was often more overt in linking issues of gender and power with distress. Not all participants who described incorporating a sociopolitical analysis in clinical work endorsed all of the techniques within each category. Some clinicians, such as Diane, Laura, and Steven, incorporated mainly process/relational values and were hesitant, for a variety of reasons, about utilizing a didactic consciousness-raising approach in therapy. Laura, for example, named her reluctance to engage in this activity with clients as a marker of the anti-oppressive nature of her style of therapy. In contrast, Paula expressed concerns that the more relational approaches were surface-oriented and insufficient and therefore assumed a more directive, interpretive role that included some consciousness raising and skills training. Many other clinicians, such as Felicia, Theresa, Yvette, and Margaret, tried to utilize a variety of techniques.

Participants' patterns of incorporating sociopolitical techniques in therapy with women are presented according to participant in Table 2. As in Table 1, participants are organized on the basis of their identification as feminist therapists, feminists, or their interest in women's issues and gender. Factors influencing participants' decisions about which approaches to emphasize were based on a variety of perspectives about women's social status, the effects of women's status on

Table 2.

Participants' Endorsement of Sociopolitically-Guided Approaches

| Name | Assessment | Structure | Relationship | Highlight Social | Resolving Conflict | Socialization | Beyond Therapy |
|---|---|---|---|---|---|---|---|
| Identifies as Feminist Therapist, Feminist, or Specialist in Women's/Gender Issues | | | | | | | |
| Ellen | X | | X | X* | | | X |
| Felicia | X | | X | X* | X | X | X |
| Laura | X | X | X | | | X | |
| Margaret | X | X | X | X | | X | X |
| Oliver | X | | | X* | X | | |
| Paula | | | | X | | X | |
| Quinn | | | X | X | | X | X |
| Steven | | X | X | X** | | | X |
| Theresa | X | | | X* | X | X | X |
| Victoria | X | | X | X | | X | |
| Wendy | X | | | X | X | X | |
| Yvette | | | | X* | X | X | |
| Does not Identify as Feminist Therapist, Feminist, or Specialist in Women's/Gender Issues | | | | | | | |
| Adam | | | X | | | X | |
| Brian | X | | | X | | X | |
| Chris | | | X | | | | |
| Diane | | X | X | X | | X | |
| Grace | | | | X | | X | |
| Henry | | | | X | | | |
| Ian | | X | | | | | |
| Jane | | | | X | | | |

table continues

| Name | Assessment | Structure | Relationship | Highlight Social | Resolving Conflict | Socialization | Beyond Therapy |
|---|---|---|---|---|---|---|---|
| Kathleen | | | | | | | |
| Nadine | X | | X | | | | X |
| Robert | | | | X | | X | |
| Xavier | X | | | | | | |
| Zoe | | | | X | | | |

Note. **=inviting stance only; *=uses inviting stance as well as providing content/interpretations about social context.

their mental health, the appropriateness of therapy's focus on individual, and a range of client, therapist, setting, and other factors. These factors are discussed in detail below.

## *Theme II: Factors Affecting Clinicians' Incorporation of Sociopolitical Approaches in Conceptualizing and Treating Women's Distress*

### *Perspectives on the Relationship Between Society and Women's Distress*

The first factor relating to participants' utilization of sociopolitically-guided techniques pertained to their views about the nature of women's sociopolitical status and the effects of women's sociopolitical status on the psychology of women. Even though recruitment procedures had aimed at eliciting the participation of clinicians described by others as conservative participants in this sample overwhelmingly agreed that a number of negative social, cultural, and political forces had some detrimental effects upon women's distress. Participants described perceptions that sociopolitical factors were associated with both individual, intrapersonal distress and interpersonal conflicts in female clients' lives. Participants varied, however, in their degree of emphasis on social factors when conceptualizing women's distress.

All participants noted that some degree of attention to social contextual factors was important in their work with clients. Only a few participants, however, named a sociopolitical model as central in their work in the sense of explicitly describing that they consistently approached women with a sociopolitical model at the front of their minds and felt that it is important to use sociopolitical techniques, such as consciousness-raising, on a regular basis. All acknowledged that a sociopolitical model explains only part of the picture for any female client. A subset of participants expressed reservations about the importance of sociopolitical factors of women's distress. These issues are described below. The impact of clinicians' views about the relationship

between sociopolitical factors and women's distress on their incorporation of sociopolitically-based techniques (described above) is also summarized.

*Gender-based societal factors harm women.* Twenty-three participants voiced opinions that negative social, political, economic, and cultural factors had some impact on women's mental health. A number of clinicians described pressures on women which can be thought of as reflective of a state of patriarchy. While not necessarily explicitly using the word patriarchy, a number of participants discussed issues such as women's experience being defined in relation to men (Steven, Felicia), traditionally feminine characteristics and roles not being valued in society (Brian, Ian, Theresa, Victoria), women having less economic and political power relative to men (Quinn, Steven, Victoria, Laura, Wendy, Henry), women's lives being constrained as a result of fears of sexual assault (Paula), women's experience of "glass ceilings" to achievement in the workplace (Oliver, Margaret), and society not adequately accommodating or being sensitive to the demands of women's lives (Nadine, Diane). A number of clinicians explicitly discussed the issue of 'patriarchy' (Theresa, Quinn, Victoria, Felicia, and Wendy). For example, Quinn noted that she thinks society is set up:

> ...pro-men. I think that's where the power imbalance comes in. And I think it comes in primarily financially. And we keep seeing that every so often, they keep publishing statistics about how women make only a certain percentage of what men make. So it's set up for men, rather than against women. Men have the advantage, the way things are structured now. (520-542)

In her interview, Quinn also argued that the link between patriarchy and women's distress often relates to the stress of childrearing in an environment in which women have lesser access to resources necessary for raising children (89-129; 188-228). Victoria also described her sense of women's changing status and its' relationship to women's distress:

> Victoria: You know, I think of some of the Middle Eastern or Eastern countries, where women are...well, I think of China, where baby girls are not wanted. There are so many other countries as well where women are hated, are second-class citizens, are despised. I mean, I don't think that we have that blatant misogyny in North America, but I certainly think that we have a very pervasive, subtle form of misogyny in which women are not valued as much, and I think that they certainly are not taken as seriously. So I would say that in this culture, although it is better than some others, women are certainly not valued, heard, seen, perceived...And you could break that down. I mean, there are so many things that happen. There are a number of factors that feed into that. I think that most studies show that women's self-esteem is much lower than men's, right? General self-esteem.
>
> HG: I may have misunderstood what you meant by "breaking it down".
>
> Victoria: Well, I would just say that globally, even in North America, women do not have the same social status of men. I mean, I think we have come somewhere since the 60s. Like, I do believe that the 60s and the 70s did something. It opened doors and opened some peoples' minds and I think that now we've almost hit a plateau. I think we're not going forward as much, when I think of some of the young women that I've taught or am familiar with, I think that they are certainly not as militant as we were in the 60s. I remember some of the reviews that came out a lot in the last decade that said that because younger women have a better position than say, women did in the 50s, they now accept that it's somewhat better, and aren't fighting with the same kind of enthusiasm that we were fighting with in the 60s and 70s. Because it is better in some ways. Certainly education is better. But if you look at the gender ratios in most professions today, it's not that bad. Right? If you look at psychologists, lawyers...so you have a pretty good ratio in terms of who's entering the profession, but...if you look at who is holding the positions of power in these same professions, who are making the top salaries, they're disproportionately male. But you have...so I think that we have come somewhere, but, there still is a lot of inequity. (271-348)

In these and other examples, a number of participants noted opinions that society is, in many respects, unequal for women. Although this state of affairs is changing, continuing inequalities in economic, political, and other aspects of power continue to be a source of distress for women. Many participants also noted that at least some aspects of a traditionally feminine gender role and traditional gender role socialization were ultimately disempowering for women. Participants listed such negative socialization patterns as putting the self last, being overly compliant, lacking an appropriate sense of entitlement, and having underdeveloped self-assertion skills as some

aspects of gender-role socialization that could ultimately disempower women. Some explicitly tied these socialization patterns to issues of women's broader societal power. Henry discussed some broad patterns of which he is aware:

> My assumption is that men are socialized to take care of their own needs first. Whereas women are socialized to take care of others first. Now, of course, that's a notion that we all thought died in the 1950s. In my experience, I don't think that it died in the 1950s. In my experience, I don't think that it died as much as we want to believe it died. I think that there are more autonomous, independent females out there. But to think that now we've come full circle and everyone's raised the same now and everything's fair, I don't think so. No. I think we still have the same dynamics for raising boys and girls, and then, some of our institutions reinforce that. Marriage does that, in the sense of traditional marriages where the woman stays home and raises the kids, anyway. They are dependent on their husbands. He has the money, and this is a money-focused culture. There are realities. They are dependent. They are often stuck. Where are they going to go? They don't need the husband any more for emotional needs, they likely distanced themselves a long time ago, but they can't get out. Where are they going to go? They're trapped. And so that reinforces female dependence. Men don't feel that way. If anything, they feel that women are taking away that sense of independence because of all of the responsibilities they have to deal with in the home. (440- 473)

Felicia, a feminist therapist, emphasized the limiting and denying effects of socialization practices in a more politicized manner. She noted:

> I think that living in a patriarchal culture, where so much about women's lives are not determined by them, and where women, from the time before they're born, have less rights, power, access, to everything, really. I think that that is really a cause of their distress. I mean, I'll be a little tangential here, but I'll tell you that I was with a group of people, and they were talking about little boys and little girls, and how little boys are so much tougher to parent. They're wild, they're rowdy, and little girls are so much more compliant and nice. And it was as if that was a good thing. And I thought, "Oh my God, I think that's a great example of what you would call oppression and patriarchy. That little boys are allowed to do and be and even though it's considered to be bad in a way, in the end, it really serves them well. And it doesn't serve women well to be compliant, nice little girls. And that's oppression. Girls are not socialized as much to be wild and free and it made me sad because I thought about those poor little girls, twenty years down the road, what their struggles were going to be. How much they don't know about themselves. How many rights they actually won't know that they have... (396-458)

In general, there was agreement amongst participants about the existence of sociopolitical contextual factors which disadvantaged women. These factors were also described as having some negative impacts on women's health.

*Type of effects: intra and interpersonal distress.* Clinicians in this sample noted that sociopolitical factors have both intrapersonal and interpersonal repercussions. Quinn noted that many clients she sees experience heightened levels of personal distress and physical illness as a result of their efforts trying to cope and raise children in an environment that does not value their efforts and permit equal access to the resources needed for parenting. Some participants alluded to intrapersonal effects of disadvantageous socialization patterns or women's lesser social status. For example, Paula noted that women often lack a sense of entitlement and feel guilty for wanting things for themselves (608-621), while Victoria, Oliver, and Brian touched on issues of client frustration and low self-esteem in work and larger environments that devalue women's roles. Other participants, such as Theresa, Yvette, Oliver, and Felicia, described some of their clients as experiencing internal conflicts regarding adhering to gender-related expectations and their own preferences and inclinations. For example, Yvette and Theresa both discussed working with clients who were in conflict over external and internal demands that they behave in a traditionally passive manner when this style was not helpful in meeting their goals.

A number of participants also described that sociopolitical factors create interpersonal distress in women's lives. For example, Quinn noted that marital relationships often break down when women are stretched too thin and have little support (89-129; 188-228). The notion that interpersonal and even intergenerational conflict can result from social forces that disadvantage women is also evident in Steven's words. Here Steven also alludes to the ways in which issues of

culture and generational cohort may complicate issues of women's power and its relationship to women's distress. Talking about his work with families, he notes:

> That's where it [issues of gender, power, and distress] comes up over and over again. There are wars going on that are started eight generations ago, because mom was born illegitimate and was raised in shame, and great grandpa was an alcoholic and abused his kids sexually, and grandma decided she was never going to marry a guy like that, and she married a guy that she had nothing in common with, so then he was closer to his kids than he was to his wife...These things go on and on and often have to do with gender politics. Women have had to stifle their creativity, and so they have a lot of anger about that, so they took it out on their daughters, and when their daughters were reaching an age when they expressed themselves, sometimes there was mother-daughter stuff going on five generations back. An example would be the oldest daughter who was very smart and creative, her brothers got to go to school and she was told to stay home and to take care of the family because mom needed a helper, and she was 14, and had her whole life she wanted to live. Then, when she grows up, and her oldest daughter is 14, she's angry with her, because she thinks she is spoiled. And so she has this grief, and she passes it down, and its a gender issue, at least, it started as a gender issue. It started as women being treated differently than men, and being denied their potential. One of the places I have seen it a lot is in Mediterranean cultures, where you will get this love-hate relationship between mothers and daughters because the whole family is so male-oriented that you'll get women who have devoted their lives to their husbands, who have a lot of free range, and they become matriarchs in the family. And then, the family moves to North America and the daughter says, "I'm not going to do that! I'm going to school!" And mother gets mad at them because they are being uppity and then the daughters are caught between family loyalty and being like mom and going to University and expressing themselves. A lot of conflicts, inside and out. So those kinds of things are gender issues and they get passed down through generations, and they find expressions in a lot of ways... (725-815)

In sum, women's position within a patriarchal culture was perceived to have both emotional and physical and intra- and interpersonal effects on women's health.

*Perceived degree of influence on distress.* Participants' emphasis on incorporating sociopolitical approaches in therapy with women was related to the strength with which they believed gender and power issues to be linked to women's distress. In this sample, clinicians varied on the degree to which they felt issues of gender and power were related to female clients'

distress. A few participants (Felicia, Quinn, Laura, Victoria) explicitly indicated that they held gender and gender-related sociopolitical factors to be very important variables in women's distress, and that this would motivate them to emphasize sociopolitically-guided approaches in therapy. For example, Felicia noted that: " I'm very feminist in terms of looking at how this person's gender and messages about gender affected their life, affected the therapy we do...so this always plays a role in all my therapeutic interactions... "(72-84). She also noted that:

> I think I would be reluctant to say that it was all about oppression, because I think that we all have different ways of reacting in the world and we all have different family backgrounds, but I do think that oppression plays a key, key, role. (374-386)

Similarly, issues of women's lesser power were an immediate and central aspect of Quinn's interview, while Wendy noted that she always tried to be aware of the impact of social contextual issues on women, just as much as she tried to attend to other important factors, such as individual and biological factors (191-214). These participants reported being primed to consider issues of gender and power when working with a female client, and examples of the use of sociopolitically-guided approaches in therapy also tended to be more prominent in their interviews than the interviews of participants who did not emphasize the society-distress link.

While the perspectives described above set the stage for participants' incorporation of a sociopolitical analysis in clinical work, three participants within the sample described their reservations about such an incorporation by questioning the degree of relevance of women's power to their distress. For example, Brian expressed the view that women's status relative to men was perhaps not so different:

> I could go on and on about what it's like to be a white male and how while everyone else thinks that I'm accorded all sorts of privileges, I feel like I'm the last guy that gets to get in line anymore. You know, I'm a white male, so I'll get hired if there's no one else available... (1726-1742)

Similarly, although she did describe conducting some consciousness-raising with clients with eating disorders, Jane noted that part of the reason she did not emphasize this more in her conceptualization and treatment of clients related to her sense that, at least within middle-class environments, women enjoy relative equality, and that she had not experienced oppression based on gender (599-614). In addition, Diane reported she simply wasn't sure or convinced that issues of power were meaningfully related to distress in such a way that therapists should take pains to make this a focus of concern with each client (895-897). In all, these participants indicated that their reservations about the relationship between gender, power and distress led them to be cautious about the degree to which they incorporated a sociopolitical approach in therapy.

All participants noted that sociopolitical factors were only part of a wide range of forces influencing the distress experienced by female clients. In stressing the idea that gender and power issues were only part of a larger picture, participants emphasized individual intrapsychic, broad cultural, historical, and economic issues, issues of birth order, sexual orientation, race, and spirituality. The significance of women's biology as a factor in their distress was also a recurring theme. The excerpts below illustrate clinicians' views that several levels of variables tend to interact with sociopolitical factors in creating women's distress:

> I think that for women, gender is one part, but there are other issues, too. I mean, for her [a client for whom issues of gender were important], there are birth-order issues. This client was a firstborn. And that is significant, because she kind of developed into her mother's helpmate, and all of that kind of stuff. And also, her confidante, which was not too helpful for her. And, in her case, she's also old money, fifth generation Toronto. So we have all that kind of cultural context where you don't talk about feelings much, and if you do, it's whining, and so one of the issues we that she had to struggle with being depressed and on antidepressants was the whole notion of failure and that she was a whiner and blowing things out of proportion. So the ethnocultural stuff is often, and other organizing principles together, it can be quite significant. And in total, I mean, if you look at the percent of variance, for her, women's issues may have added to 20 or 30 percent of the variance of her issues, not even the majority, but certainly

> worth looking at and not insignificant, but not necessarily the be-all and end-all for her. (Ellen, 262-300)

> Well, there's a whole dilemma about what is it that's keeping people stuck. Is it out there, or is it in here (points to head). And almost always, it's some of both. Sometimes it's out there, and so it comes to be in here (points to head). And sometimes it's in here, and so I make it happen out there. Or sometimes, it's in here (points to head) because to some extent, it's out there, and then I self-censor, and I close myself down, and it's a continual back and forth process. (Laura, 878-890)

> "I think I see oppression in other terms as well as just the oppression of women. There's race, sexual orientation, class. Gender is one of them and they intersect." (Yvette, 799-804)

> Well sometimes the family of origin issues can totally override the social context issues. I'm seeing a young man, for example, who has a second episode of very severe depression with psychotic overtones. You don't see that really often. And he has, quote unquote, a lot of social things, too. You know, he's part of the Jewish community in Montreal-Toronto, which is a whole subculture that you need to understand, and lots of other stuff, but the main thing is that his father died of a protracted illness when he was an adolescent. And that's 90% of the variance with him. So he has a social context, but in fact, his family of origin issues are most significant. Similarly, a biological illness. Like a kid has a psychotic illness, early adult onset schizophrenia. And you can have various constellations of sex roles, family issues, and stuff like that, but schizophrenia is such a dramatic, serious, overwhelming illness that it just tends to be devastating. It's like losing your legs. It doesn't matter what colour your eyes or your hair because you don't have any legs. It renders everything else irrelevant, really. So some things overwhelm the social stuff. (501-561)

> And I think that women just feel a lot more their own emotions as well as the emotions of their children, the emotions of the family, and I think that can lead to a lot more distress. They feel more responsible. I think it's probably genetic. I think it's probably hard-wired. Um, I mean that I think...that's it's probably hard-wired. (Victoria, 194-249)

Social factors, therefore, were believed to influence women along with a wide range of other factors that could sometimes override the relevance of a sociopolitical approach in therapy. In general, the perception that gender-based sociopolitical factors were only one part of a larger,

complex system of influences led clinicians to assume a more individualized style of intervening with clients.

*Summary: Relationships Between Society and Women's Distress*

All participants in this sample described perceptions that at least some of women's distress can be related to women's lesser social power relative to men. They discussed how issues of socialization, structural inequalities, and the lower valuation/status of women were related to women's individual and interpersonal distress. Most participants also described ways in which social factors interacted with other factors in producing the distress experienced by their female clients. Participants' degree of emphasis on sociopolitical causes appeared to be associated with an emphasis on the use of sociopolitical approaches in therapy. Among a small subset of participants who immediately and/or repeatedly stressed the importance of understanding the social causes of women's distress, examples of the incorporation of sociopolitically-informed techniques with women in therapy also tended to be prominent. The use of sociopolitical approaches were relatively less central in the interviews of other participants who did not frame social issues as centrally and crucially. The three participants who questioned the accuracy of models that linked gender and power with women's distress reported that they nonetheless sometimes used sociopolitically-guided techniques in therapy with female clients. They emphasized, however, the idea that a sociopolitical model was not central to their work.

It seems self-evident that clinician's endorsement of sociopolitical views of women's distress is a logical prerequisite for utilizing sociopolitical techniques involving, for example, discussion of women's power or remediation of the perceived limitations of women's gender-role socialization. While this is true, at the same time, the relationship between endorsing ideas that social factors

disadvantage women and using sociopolitical techniques in therapy was not a direct and straightforward one. Not all clinicians who outlined a link between women's power and distress utilized the sociopolitical techniques described above. In addition, not all participants who made this link used all forms of the sociopolitical techniques described above. Some participants, such as Steven or Laura, for example, described their beliefs about women's distress as feminist, but reported that they did not agree with using the consciousness-raising approaches described earlier. Others felt that consciousness-raising was important for clients. To better understand why participants did or did not emphasize a sociopolitical approach in therapy, and to understand their patterns of choosing some sociopolitical approaches over others, one must address other important factors. The second most important factor associated with incorporating a sociopolitical approach emerging in this sample pertained to the clinician's attitudes toward the major therapy rule of focusing on the individual. This and other factors influencing the incorporation of a sociopolitical analysis in therapy, are discussed below.

*Emphasis on the Individual and the Intrapsychic*

A very important theme emerging from participants' descriptions of clinical cases, philosophies of treatment, theoretical orientation, and attitudes toward using sociopolitical techniques pertained to the importance of focusing on the individual in clinical work. This theme of focusing on the individual, evident in all participants' interviews, was an overarching, abstract theme representing commonly and strongly held standards for conducting clinical work with clients. As such, it represented the parameters or context within which an incorporation of a sociopolitical analysis of women's distress in therapy took place. Basically, for participants, focusing on the individual in therapy meant that the therapist needs to help clients find individualized solutions to

their problems and to see clients as unique and complex persons whose presenting problems are potentially associated with a wide range of influencing factors. Clinicians must also have a variety of models of treatment in their repertoire, and fit the stylistic aspects of their approach, or more substantially, their overall model of intervention to suit the characteristics, needs, and preferences of their clients. At the same time, however, focusing on the individual often meant that intrapsychic and/or microsocial factors, such as family or small group dynamics tended to assume a privileged role in clinical work and be seen as the real work of therapy. An analysis of the wide range of clinical cases described by participants suggested that three common ground themes of intervening with clients emerged/could be identified. These themes included: 1. Using the relationship to effect personal change; 2. Helping the client to gain personal insight; and 3. Facilitating new skills and experiences. These themes involved an individualistic, often intrapsychic or microsocial focus.

In addition, for the participants in this sample, focusing on the individual also meant that clinicians must avoid imposing their own values on vulnerable clients. More specifically, clinicians may promote some global goals and processes, such as gaining personal insight into problems. At the same time, however, participants warned that clinicians should avoid imposing specific viewpoints or choices on clients, something which was seen as more value-laden and disrespectful to the individual than more global therapeutic goals.

Participants' degree of emphasis on a sociopolitical analysis in therapy, as well as their choice of sociopolitical techniques used, appeared to be related to their concerns about the congruence of a sociopolitical model/techniques and an emphasis on focusing on the individual in therapy. When participants objected to the use of certain degrees or forms of the sociopolitical techniques described above, they tended to do so on the basis of their concerns that sociopolitical techniques

would violate therapy's rule of appreciating the client as an individual. In contrast, when a smaller subset of participants reported that a sociopolitical approach had a relatively high impact on their clinical work with women, they tended give a rationale that emphasized the harm to women of an overly individualistic and intrapsychic psychology. Amongst clinicians with both kinds of concerns, an emphasis on respecting and following the individual shaped the nature of the sociopolitical techniques they chose to use.

*Concerns about incorporating a sociopolitical approach: you might lose the individual.* Several participants reported having concerns about the degree to which a sociopolitical analysis of women's distress should be allowed to guide clinical work with women. Many participants expressed worries that such an approach should not automatically be the main model for understanding and intervening with clients. In situations in which such an approach was prominent, participants were concerned that it might potentially violate the standard of focusing on the client as a complex and unique individual. These concerns tended to pertain to the use of didactic consciousness-raising approaches in particular. Negative constructions of feminism appeared to underlie many of the concerns that a sociopolitically-guided therapy would overlook the individual and involve the inappropriate imposition of a political agenda in therapy. Specifically, some participants reported concerns that feminist models might be vulnerable to overlooking individual complexity, were insufficient as models of distress and treatment, and could therefore lead to improper treatment which alienated clients. In addition, some participants implied or suggested that some feminist models might be proscriptive, dismissing individual clients' goals and values by instead promoting specific messages of "having it all" (Diane, 1034-1068; 1150- 1253) , victimhood (Jane, Diane, Nadine) and/or blaming, "antimen" sentiments

(Margaret, Quinn, Kathleen, Theresa). These concerns about sociopolitical therapy with women will be described below.

Concerns about the effects of a sociopolitical model in therapy were expressed by a wide range of participants that included those who explicitly labeled themselves as feminist. In a few cases, participants noted that these concerns led them to avoid utilizing sociopolitical models in clinical work, while most others still saw the helpfulness of a sociopolitical perspective but emphasized the primacy of the individual and a corresponding need to restrict the application of sociopolitical models in favour of other factors in specific cases. Some others noted that their concerns would lead them to follow the individual and emphasize the more nondirective, inviting, rather than didactic sociopolitical techniques in therapy.

*Concerns about degree/dogmatism of a sociopolitical approach.* Most of the concerns raised by participants reflected the perception that, when used as a major guiding model for therapy, sociopolitical models of women's distress ran the risk of being dominating in nature. Although some participants noted that rigid adherence to any one model of intervention (including individualistic ones) could result in losing sight of the individual's complexity and concerns, some raised concerns that sociopolitical models of women's distress were particularly vulnerable to being used in a heavy-handed manner. Talking about some therapists' propensity to see issues of gender and sexual abuse as causal to some forms of personality disorder, Jane, for example, warned that women's issues may be vulnerable to dogmatic, simplistic explanations (381-460). Instead of dogma, Jane advocated that clinicians continually go back and forth between their in-depth knowledge of the individual and their knowledge of gender and sociopolitical issues (450-460). Nadine and Margaret reported that they had first-hand experience working in settings in which a feminist approach was rigidly applied, while Grace and Zoe noted that they perceived that

work in some settings, such as sexual assault counseling centres or women's shelters ran the risk of being unhelpfully and forcefully political in nature. Nadine, a psychologist working in a forensic setting, noted that:

> I think that the area of family violence hasn't gone as far as it could have because people involved have adhered to a fairly ideological perspective, a single factor approach for too long, and that they were made to feel that they were not really au courant, or not really caring or supportive of women if they challenged a feminist approach. (1104-1116)

Later, she clarified this perspective with an example:

> HG: And you mentioned that that kind of an approach...I guess...correct me if I'm wrong, easily becomes a dominating approach?
>
> Nadine: Well, it's ideological, and because it's ideological, it's not challengeable, do you know what I mean? Because you're made to feel that stepping outside of that, you're politically suspect. When the family violence prevention program was started in X, there was an awful lot of pressure. Political pressure...for a single-factor approach. And in fact, there were threats, such political pressure that we would even be intervening with men, even providing services for men, that they agreed not to provide services for abusive men. In other words, no treatment programs for men who are abusive because the money was being taken away from women. That was the idea, and the approach we ended up with was very feminist, and the language was very strong, and the men in the program didn't like it, and understandably so...and I think that we did a certain amount of harm. (1174-1214)

Most other participants did not have first-hand examples such as this, but voiced concerns that sociopolitical and feminist perspectives should not be used in a dogmatic way. The frequency and spontaneity with which participants raised these concerns during interviews could be taken to imply some degree of shared perspective that sociopolitically-based approaches may be vulnerable to being used in a dogmatic manner.

*Missing the complexity of the individual.* Many participants' concerns about the degree of focus on sociopolitical factors was related to their perception that a sociopolitical model was insufficient as a major approach to treatment and that clinicians might therefore miss out on

other factors relevant to a client's difficulties. For example, Nadine noted that although she believed that taking a sociopolitical approach certainly helped therapists better understand and be more empathic with clients, concepts such as patriarchy were simply inadequate for conceptualization and treatment:

> Nadine: Well, I think that it's important to take a woman-positive approach. It's helpful to understand the circumstances that they have come from, and the situations that they are going to cope with, which is considerable. [Referring to her clients:] Certainly poverty, almost all of them. Certainly children whom they have been separated from. A social services system that isn't always sympathetic to difficulties in women's lives. It would be foolhardy not to appreciate that. So if that's a feminist approach, that would be useful. I don't see the concept of patriarchy as a useful explanation for why women are in the situation that they are in. For why women end up in forensic settings.
>
> HG: Can you elaborate on that side, because I think that that is an important point of view.
>
> Nadine: I don't see that helping them understand...or even coming from a feminist treatment approach that holds that the role of men and women in society is critical to understanding women, or women's distress or the lack of women's options. I don't see that as all that helpful in working with women.
>
> HG: Okay.
>
> Nadine: In the area of family violence, that's been an important approach in the treatment of family violence. It's played an important role in women's advocacy, and of course, who could be against that? Wanting to find support and services for women who are in desperate circumstances. And I think that the sense of entitlement that some men, especially abusive men have felt, to control women and to exert power over women, can be helpful in understanding their motivations for being abusive. But it's extremely limiting as a single factor explanation of why men are abusive, or why women stay in abusive relationships. (1028-1116)

Nadine went on to say,

> ...certainly, there are other factors. We did an analysis of same-sex violence. There is a high rate of same-sex violence and the issues tend to be similar there. So it's not just patriarchy. It's not just gender. Power and control inherent in a lot of factors explains it. "I want you, as my partner...I don't want you to have contact with others and I'll do, and I'll feel entitled to do, whatever I want, to keep you with me..." These are issues that are not necessarily motivated by

> patriarchy, although, I mean, men can use patriarchy as an excuse. "You will do what I say because that's what's expected of women!", and "That's the way my father told me women behave and men behave..." So you know, they use it as an excuse to be violent, but you will also find violence in situations in which patriarchy can't explain it. And so we can't just stick with that as the explanation in helping people.
>
> HG: Is what you're saying is that kind of an analysis is useful but it's not sufficient by itself...is that what you're saying?
>
> Nadine: It's not adequate. (1127-1172)

Similarly, Jane noted that a strongly sociopolitical orientation may result in missing other crucial factors. She also proposed that to avoid this, a therapist needs to focus on the individual client:

> You know, I think that if I went to see someone for therapy...I wouldn't want them to have a perspective of, "Okay, here's a woman, and she must be dealing with all these women's issues," and you know, I think that that would really miss the boat for me. Or, "If she's depressed, she must be depressed for these reasons, because, aren't all women?" It's just...you want to really be discovered for who you are, you know? What your background is. It's too simple. There are always so many factors involved. And I think that it goes for any model a person could use. You could take it from the other side, too, and say that. For example, you just go in with an analytic model and you could argue that you miss all this cultural context. So you could look at it from both ways...
>
> HG: Yeah. So what is the answer for you then?
>
> Jane: I don't know. And in the end, you know, you just end up being with the person, and listening to them, you know? And giving it your best shot in terms of what you think might be going on. (689-716)

Similarly, Adam noted that we should never see sociopolitical factors as the "one unitary dimension" of importance (737-743), and Ian and Brian stress the importance of appreciating the complexity of individuals and the idea that sociopolitical issues are never the only issue that need to be addressed. Overall, then, many participants expressed concerns that a highly politicized approach to therapy may lead the therapist to overlook other crucial factors.

*Resolution of individual and intrapsychic issues are the real focus of therapy.*

Some participants (including Ian, Jane, Diane, Paula, Laura, and Kathleen) voiced concerns that the use of a sociopolitical model in clinical work might slight the individual, idiosyncratic, and intrapsychic factors that are the real focus of therapy and area of expertise for psychologists. In general, the argument here seems to be that although gender and power may be more or less important in any given case, intrapsychic issues are always important and therefore need to be the primary area of focus. This view is reflected in an excerpt taken from Jane's interview:

> I think that if you go into a situation with too much knowledge about the possible context, of all the social factors, you can paint the person with a pretty broad brush, and really miss those individual issues, and I think that are that much more personal, or that sort of could happen to anyone, male or female, depending on some very specific factors. And I think that I have tended to go in that direction...I suppose that that's a very psychoanalytic bent. Sure, you know, there is a context and all that, but there are intrapsychic forces going on, too, that are key, sort of idiosyncratic, or common to both genders, and I think that that's where the real work is. (340-373)

Ian also offered reservations about using a strongly sociopolitical approach. During his interview, he stressed on several occasions that the most important thing a competent therapist requires is a firm grasp upon some model of individual, intrapsychic functioning:

> Ian: Well, surely an individual's distress is motivated at least in part by everything that touches their lives.
>
> HG: Is what you're saying that if you make [sociopolitical analysis of women's distress] the forefront, without an understanding of basic psychological functioning, how people are organized and make meaning of what's going on, you really miss the boat?
>
> Ian: Well, I think so, and I think that while for some people, some of those social and political factors may be, to some large part, what is influencing them. But it is still expressed and filtered through how they basically function as a person. So you can't only know about these [social] issues. (966-1024)

Ian went on, emphasizing the fundamental focus on the individual inherent in the tradition of psychology:

> Ian: I don't think that it will be helpful to assume that cultural, political, or social issues are the cause of all people's problems in a sort of unfiltered way that doesn't take into account aspects of other important factors that have an impact on people's behaviours that they show.
>
> HG: So you can't let go of the complexity and you need to follow the individual.
>
> Ian: And I suppose that's why we're psychologists rather than sociologists, because in psychology the focus is always on the individual. That doesn't mean that you don't take into account and give appropriate attention and importance to all these other factors, but the focus is really on the individual, and while you can understand something about women in general by looking at important political and social and cultural issues, you're not going to understand Jane Doe specifically by looking only at those issues. Because that's not the whole picture. It's only part of the picture.
>
> HG: Sociologists look at groups, we work with people...
>
> Ian: Sure. It's not about being more valuable or less valuable, it's about the focus of attention, which in psychology is on the individual and understanding that person and their behaviour. It's just a different focus of attention. A different level of study. A different level of analysis. It's a question of orientation, and it really has assets because its' subject matter is different than other disciplines like sociology or political science. (1003-1051)

Throughout his interview, Ian also emphasized his perception that an intrapsychic, psychodynamic focus, with its' emphasis on universal intrapsychic functions, have been particularly important in his work with a wide range of clients:

> Ian: I don't think that you can do a serviceable job in helping somebody by only looking at the times in which they live. I think that you need to have some understanding that works for you about how people function. And how people work, so to speak. Just like a car with its engine. You know, you don't necessarily have to...You have to know how it works, and over the years, I've always found most useful a more psychodynamic understanding of how people function. (640-655)

Some participants noted that they focused on individual factors rather than engaging in consciousness-raising about women in general because of their sense that women are already knowledgeable about the impact of gender and social pressures, but did not have an adequate awareness of their intrapsychic functioning:

> Well...I think that, they already know that. But maybe what they don't know is how they, as an individual, connect to that and what makes them, as an individual, particularly vulnerable to that. Some women are more vulnerable to that than others... (Diane, 613-646)

Similarly, Laura noted that she did not conduct consciousness-raising because of her sense that clients are already aware of gender and power issues. Talking about socialization issues and how it related to her clients' distress, Laura noted that she typically did not discuss these issues in an abstract or didactic way with clients. She also perceived that clients wanted to focus at an individual level:

> Laura: Usually I try to talk about it that in a more individualistic kind of way, in the sense of, "So what are some actual things that you could do in that situation? If you can think of your partner, or your friend, or, what might someone else do?" I think that most women who've been socialized in this society have a really...haven't articulated it, I think, but have a very clear understanding of power dynamics and they don't...I would say that most women don't necessarily want to talk about it in this sort of theoretical way. That men can do this and men can do this and men can do this...But I do think that they have the feeling that, [assumes an exasperated voice] "God!" And most girls get taught that there's a line. And do you know what I mean when I say that? There are certain things that are acceptable, and here are certain things that are not. And so, you know, you don't have to tell anyone about the existence of that line. What you have to do is...And I'm not even all that big on making sure that they understand, in a theoretical way, how to talk about it. And you know, that everyone grows up with that line and that it's usually in a very different place for men and for women. It's usually in a VERY different place depending on your racial background, and a whole host of other things, interacting. Absolutely. And so it's less of that and more like, "Where is the line for you?" Right? And, "What if we pushed it back just a bit? What can you imagine yourself doing? Can you imagine how that would feel, can you imagine how you would go about doing that? Can you imagine how people would respond? What would it be like if you tried that?" And so, in a sense, I would say that, um, that that sort of male-female difference and the question of

> how we're socialized, and what women are supposed to do and what men are supposed to do...it becomes part of the background, rather than...the forefront. It's stuff that almost all women have experienced, but we're not talking about it at that level, but it informs what we do.
>
> HG: So the focus is always on the individual and what her experience is, the difficulties associated with taking a particular line of action, one way or another, and how she sees...
>
> Laura: Yes. (507-573)

In summary, then, some participants reported that attending to individual, intrapsychic factors, rather than a discussion of general gender and gender-based power issues, was most appropriate for therapy.

*Group statistics don't tell you about the individual.* Some participants' concerns reflected the idea that a highly sociopolitical approach to therapy may be insufficient or result in misclassification due to the fact that group characteristics, including those pertaining to women and power, cannot be assumed to be true of all individual clients. Brian emphasized this when discussing his reservations about models of therapy that focus on gender and women's experiences:

> I guess, one of the things I've always had a problem with is the notion that we ought to come up with a groupwise excuse for why things happen, and that therapy is nothing more than just an adding up of facts or columns of things and saying, "...Okay, here's the deal. It's a 13-B-27, and, oh yes, that's because you also grew up in a certain block of the lower east side..."and that that necessarily means anything, you know? You know, for example, it occurs to me that there are African Americans who don't feel that there's a particular disadvantage to being African American... (1624-1631)

Brian acknowledged that although information about women's experiences as a group can be useful, he recommended that therapists should take a cautious approach, consciously suspend immediate judgements and take a careful, verifying approach to determine the relevance of women's issues with individual clients. He also described his consternation about the tendency

for some therapists to uncritically assume that borderline personality disorder results from abuse, for example. He noted:

> At a meeting the other day, someone made a presentation about borderline personality disorder. One of the things that she brought up, and this was a psychodynamic article, had to do with childhood sexual trauma as a precursor or causative factor. Might be. For some people with BPD. But I don't think that even these authors would contend that all people with BPD were traumatized sexually as children. You can make a whole lot of assumptions about things that may turn out to be untrue. The danger with that is that you add something on, and you push somebody in a certain direction. Now, not only do you have BPD, but you've been sexually abused. And if you remember about the whole repressed memory thing a few years ago, there were several people who got into some serious trouble on the basis of some accusations that turned out to have no merit at all. But we had therapists who were encouraging people to recall burning crosses on lawns and sacrificing on altars. If there was really as much Satanic worship going on as some of these therapists contended, there'd be a glow from burning crosses every night, or whatever. It became ludicrous. Now that doesn't mean that there's not people out there who haven't been traumatized as a child. And it might not even argue against the idea that one of the risk factors for BPD might be childhood sexual trauma. And I think you ought to look at that, and know about that, and you ought to, very carefully, gently, inquire about that. But if it looks like it's not a relevant issue, I don't think that you should keep insisting to your patient that he or she is wrong. 'You must have been traumatized! See how badly you've repressed it!', you know... (2021-2115)

This excerpt also highlights the issue of fears about victimizing clients. This theme will be discussed in greater detail shortly.

Similar to Brian and others' concerns about using a sociopolitical approach to women's distress, Ian described a number of general examples in which assumptions based on expected group patterns can often be incorrect with individuals and potentially lead to improper treatment. Discussing the example of men experiencing adjustment to cardiovascular disease, he distinguished between men who become depressed as a result of their inability to fulfill gender-role expectations, and others who simply find it hard to break habits associated with a Type-A personality. Discussing this, he noted,

> Ian: So the point I'm trying to make is that even with the same presenting symptoms, you can't assume that they have the same problem. The thing is, people don't always have the same problem even if they have the same symptoms. And similarly, people aren't affected in a uniform way by the culture and the society in which they live.
>
> HG: So you really have to suspend your assumptions. You can't go in knowing the answer.
>
> Ian: Yes. (1163-1257)

Similar to Brian and other participants who voiced concerns about applying models derived from groups on individuals, Ian advocated balance, flexibility, and a careful, individualized focus rather than a dogmatic, heavily sociopolitically-guided approach to therapy.

*Failing to meet the individual where they are at: imposing your political agenda.*

Eleven participants expressed reluctance to engage in consciousness-raising techniques with clients as a result of their perception that this might result in a failure to meet clients where they are at and keep their need for inner self-exploration, self-definition, and personal goals central. Participants were also concerned that an emphasis on this form of technique might result in the therapist inappropriately imposing a political agenda on the client rather than facilitating the clients'exploration and development of their own agenda. Among these participants, some (such as Zoe) acknowledged the impossibility of value-free therapy but rejected perceived feminist values and techniques due to their perceptions that they were particularly likely to be dogmatic or proscriptive. Other participants, however, implied or argued that therapies which emphasized individual insight did not inherently involve the imposition of values. These latter participants (such as Ian) saw the goal of gaining personal insight as relatively value-free, and instead defined the imposition of values as the prescription of specific life choices based on this neutral insight. They believed that feminist therapy theories were particularly likely to prescribe specific life

choices for female clients. Although she disagreed with the view of consciousness-raising as imposing an unwanted agenda, Felicia, a feminist therapist, noted that she has encountered this concern amongst mainstream therapists:

> That's what people think, right? It's that you're being irresponsible, and you're placing your agenda above theirs and you don't want to take people away from their experience and distract them, and the person's not there for a lesson, and you're forgetting about them... (936-945)

Laura, who described her style of therapy as highly feminist, noted that she was wary about a didactic consciousness-raising approach due to its potential for distracting from the individual's goals in seeking therapy. Laura noted that most of the time, her incorporation of a sociopolitical analysis did not involve discussing feminist issues in a consciousness-raising...

> ...Women's Studies 101 tradition, though. If only because that way of talking about it makes perfect sense for intellectuals, people who understand the world by thinking about it at an abstract level, and not necessarily for anyone else. Lots of clients, in my experience, have no interest at all in generalizing about women and men, or anything else. They want to know how to change something in their lives. And if that's what the client wants, I think that's what we are responsible for doing, unless we have some very strong evidence that something else would be better for them. I've got a whole rant about the arrogance of intellectuals in assuming that theirs is the only valid way of seeing the world, even though they have all this evidence to the contrary... (1196-1207).

Similarly, Nadine, Diane, and others believed that the clinicians' job is to help the client deal with their immediate problems and attain their goals. According to Diane,

> Diane: When you have a client in the room with you, it's all right to be aware of those societal kinds of things, but when it comes right down to it, it's "What are you going to do with your life?" How are you doing to be able to do it? How can we get you into the best shape to go through it, to make your way?
>
> HG: So the focus has to be on the individual.
>
> Diane: The focus has to be on the individual. At least in therapy. (1395-1418)

Steven, Henry, Diane, and Zoe's views also suggested a wariness that a highly sociopolitically-based approach to therapy may result in the therapist's agenda being imposed on the client. These participants specifically argued against the use of a sociopolitical approach which might potentially encourage individuals who value traditional gender-roles to assume less traditional roles. For example, Diane suggested that a feminist analysis in therapy might potentially pressure women to try to "have it all", rather than assume traditional roles which might actually be more suitable to some of them:

> To me, you work with the woman for her to be, for her to have, to try to have, the most fulfillment in her life, whatever that means. And I think I would....As I said, I think that when I started out, as a young woman, I thought I had to have the career thing and do this and do that, and, looking back, I think, gee, I wish I'd had more time with my kids. So I'm not so sure of myself now. And I think that feminism got tied up with the, "You should have a career, and be successful in the work world...". It liberated us in some ways, but I think that it hurt us, too. I hope we'll be seeing more of a balance. (1150-1182)

Talking about an example of a client conflicted about whether to stay home with children or go to work, Diane also described how her manner of intervening would differ now than when she was a younger therapist with more strongly 'feminist' attitudes:

> Probably, nonverbally, or some other way, I would [now] give her more support for staying home with that baby. Whereas, maybe, twenty years ago, I would've thought, "If she stays home for the next 20 years, she's not going to feel fulfilled. She must at least do a part-time job. She's going to get herself in trouble." But I think that I've changed in my thinking that way. Cause maybe we missed the boat, back then, when we thought that we had to have it all, the kids, the career, the profession. Maybe you don't, depending on the person. So I think I've become a little more traditional, because that's not what I did. So, I'd support her however she wants to go. Certainly, for most women, it's not a choice. (1034-1071)

In a similar vein, Steven and Henry (558-574) noted that feminist values should not be imposed on clients for whom traditional marriages or gender roles are important. All expressed

concerns that this could result in failing to appreciate the client's needs and preferences. According to Steven:

> Many of the systemic researchers and clinicians, like Olga Silverstein, they are great pragmatists. They use whatever works, whatever gets you through the night. I mean, they are feminists, but they are also pragmatists. If you have clients who have been raised in an environment where they feel that to be a good woman is to stay home with the kids and to be a good man is to bring home a buck, and this is what makes them feel good about themselves, then this is not the time for your ideology to interfere with that. (1338-1358)

In addition to being disrespectful to the individual, Steven noted that imposing values ultimately interfered with therapy on many levels. In describing a therapeutic mistake in attempting to encourage a traditionally feminine client to assume a different, more assertive and independent way of behaving in relation to her husband, he noted that he ultimately hindered rather than helped her to resolve her problems in a way that was meaningful and acceptable to her (1368-1510). Steven also noted that the timing and level of didactics involved in a consciousness-raising approach in therapy is associated with getting ahead of and imposing values on the client, something which hinders therapy. He makes the distinction between teaching as imposing on clients on the one hand, and asking open-ended questions and raising attention to possible issues as less educational and imposing and more therapeutic:

> I think it's very helpful to have in your head. It's not very helpful to talk a lot, except as a person leads you in that direction. Among other things, it sometimes just isn't true. It may be true in theory, but it may not be true for that person. So, sometimes, when I have come at the client with what seems like an 'Aha!' for me: 'Oh yeah, obviously!', sometimes, they don't relate to it at all, even though that's what I've been thinking. And even with something as important as a gender issue, it may be what they're feeling, but they are not there yet, and by bringing it up at that time, you may even be alienating them. If I were to say, 'Well, it appears to me that this is a women's issue,', there will be some women who say, 'Oh no! I'm not one of those! Don't talk to me about that!' And I've just pushed her away, because I'm really bringing my political agenda to her. So, unless a woman or any person comes to something clearly themselves, handing

> them something, I just don't consider that therapeutic. It is educational, it's not therapeutic.
>
> HG: So that's not what therapy is.
>
> Steven: You know, if you want to give someone a larger view, and they seem hungry for it, you can send them to a women's group as a separate thing, and it may involve increasing awareness and political involvement. There's nothing wrong with saying to a client, "You might want to check that out." That's different from giving them books to read and going back to it in therapy. I'm saying that as though I've got it all very clear when I'm talking to you. What I actually say to my clients, sometimes, that's a different story. (676-698)

Steven also noted that because of his concerns about imposing his values on clients, when gender and power issues arise with female clients, he tended to follow the client and assume a more questioning and exploring approach. For Steven, this was a less imposing, and more therapeutic stance:

> Steven: If she could come to that herself, then that would be more powerfully therapeutic than if I'm there expostulating.
>
> HG: Feeding it to her.
>
> Steven: Yes, although I do find myself talking a lot. So when I do it, I have to talk to myself so that I don't get ahead of the person. So they all find that interesting, but it's pretty intellectual, and they can relate to it, maybe they thought about it themselves, but it's not really a therapeutic intervention until it's right, until they're ready to really connect with it. So if I'm talking with someone they may say, "I feel fat". And I might say, "Well you know, that's a common issue amongst women in our society, maybe it's not just you..." And that will help some, and sometimes it's useful to...perhaps turn their attention towards it, but it would be better if we came to that more slowly. So if I said, "Where did you get the idea that you were fat?" "Well, you know, as a kid, other kids teased me..." And as they get into it, they feel that affect, at that point, or later in the session, if I were to say, "You know, do you think it's just you, or do you think that other people also experienced that?" Then they come to it, and they start putting it together themselves. That's a more powerful way of working with someone than just giving them the answer or my take on it. So it's how you frame your questions, how you time it. It may be that it makes perfect sense to you, and it's emerging from the client, rather than you doing the work for them, saying something, or hinting at something that wasn't there. I think of it as not being ahead of the person. I have a fast mind and know a lot of theory and can think,

> "Oh yeah, I know what that's about,", you know. But when you do that, what you're doing is dismissing the person in front of you, and turning them into just part of a theory. So they may get it, and they may even appreciate it, but they won't have the inner sense of having really found something to be true.
>
> HG: So you would be teaching them.
>
> Steven: Right. And they can go to class if they want that. And they might even really learn something, maybe come out with a really good understanding of something they never thought about. But it's not therapeutic. It's more educational. One of my traps as a therapist is to refrain from being too educational. (514-607)

Overall, participants in this category expressed a strong concern that putting the individual first meant avoiding the imposition of values. For some clinicians, a sociopolitical analysis seemed inherently proscriptive, while for others, it was seen as not therapeutic. This concern was associated with a focus on understanding and solving problems at an individual level, de-emphasizing sociopolitical analysis in therapy, or at least, utilizing inviting rather than didactic consciousness-raising approaches in therapy.

*Alienation of clients.* One perceived consequence of losing the individual, not meeting clients where they are at, and imposing values on clients was the alienation of clients from mental health staff. Six participants expressed concerns that a highly politicized approach in therapy could potentially alienate clients. Margaret described this concern particularly vividly. Describing herself as someone who is influenced by feminist approaches to therapy, she nonetheless noted that she sometimes has felt judged by "superfeminist" clinicians who employed a greater degree of consciousness-raising in their clinical work. Below, Margaret described her experiences working with some clients who had previously seen feminist clinicians. She first estimated that the frequency and style of consciousness-raising is one thing that makes her different from these clinicians:

Margaret: I suspect that they would probably be more of the sociopolitical. I think they would say more. They would have more emphasis on how bad society is for women. I think, just based on a little bit of feedback, they might be. I don't think it's what they say. It's the strength...because they are competent people...I think it's probably because they come across as, "Women have rights, and society has not helped us with that." And it's true. And I think that it's probably the conviction and the strength. Not really what they say, but they are probably having that strong...and this is totally my impression...my sense would be that the women we see are usually... they are not there. I'm not saying that they don't believe in it. So I can see how they can be scared by that, saying, "Oh,", you know, "I'm a far cry from that!" Whereas I probably come across as not...having no hat in particular. Like, "Be what you want,", or, "I'll take you where you're at...", because I don't think that I come across...I don't think I'm perceived as having a particular hat. So it's only when something is presented, when I'm asked what approach I have, and I say, "Oh, a little of this and a little of that..." I tend to be pretty much that way, so I think, because my sense is that for some of their clients that I saw after they saw them...they had nothing bad to say, but I think they felt that they couldn't rise to the challenge. I'm not saying that the therapists were actually giving them a challenge, but just by the strength at which they appeared to have their approach, or their belief in women, the others said, "I just couldn't have done any of the things they probably would have asked me to do..."

HG: Really? Can you tell me more about that?

Margaret: And I'm not saying that the other therapists would have made them do steps, but I think that that was the perception. Whereas with me, they had the sense, "Okay, I can just be for a while. I can just talk".

HG: So are you saying that they felt a lot of pressure to move?

Margaret: Yeah, and I'm not saying that it came directly from the therapist. It might have come from their own perception of the strength of the therapist. (1563-1650)

Margaret went on to describe her sense of feeling judged from time to time by some feminist clinicians over issues such as diagnosis and reserving therapy for women. She asked whether this sense of feeling judged might also occur with clients:

Well, there's something missing, because if they treat...If I feel...If in the presence of a person who's very feminist, I feel judged in the conversation, if I feel that there is something wrong with me, I ask, do clients feel that way, too? Am I...I feel that there's something wrong with me because I don't fully...I can only come from

> my experience. I can't say what they're lacking. But I know that I just feel judged. I feel categorized. I feel that there's something...If they're only doing that to me, then that's okay. But if it happens with me, does it happen with clients as well? (1769-1792)

Other clinicians also raised concerns that a strongly politicized, consciousness-raising approach to therapy may alienate clients and fail to meet individuals where they are at. Zoe, for example, noted that she perceived the forthright agendas of some feminist counselors at local women's shelters and sexual assault counseling centres sometimes involved a foreclosure on their own exploration of the causes and best solutions to their situations (88-123). She perceived that in some cases, this approach led women to withdraw from counseling services (88-123). Looking at their interviews, these participants did not necessarily disagree with sociopolitical explanations of women's distress or even with the use of consciousness raising as a technique. Instead, the message here seemed to be one which emphasized a primary focus on the individual's own exploration, perceived needs, and goals.

*Categorizing, limiting, and marginalizing women.* Five participants in this sample expressed concerns that sociopolitical models of women's distress fragmented a common human psychology and placed women and men in totalizing, growth-limiting categories that denied their individuality. While some participants contributing to this theme simply argued that they perceived men and women to be more similar than different and therefore not requiring special approaches in therapy, Chris' comments were more elaborate. In discussing his sense that a gendered focus needed to be balanced with an appreciation of both common human and unique individual issues, he also noted that the separateness he perceived to be promoted by some feminists ultimately did not serve women:

> I have a concern that you don't want to fragment psychology into not appreciating that these issues are a shared human experience. For example, on a broad basis, I

> don't believe in a psychology of women and a psychology of men, and a psychology of psychotherapy with a gay male, or with lesbians, or with immigrants. Not that there aren't very important issues that are unique to each of those populations, but it's the recognition that it's that uniqueness that is indeed part of the shared human experience. (1073-1565)

Chris went on to describe the negative political effect emphasizing difference has had for women:

> Chris: I think, that to a certain extent, that's what's happened to the National Organization for Women. That in their political zeal, they promoted a separateness that actually fed right back into the hands of the people who wanted to maintain the status quo.
>
> HG: So it strengthened it?
>
> Chris: In some respects. They wound up being...having no credibility. And so my concern with this is the same thing. We need to identify these unique factors, but then not use them to further fractionate. (1729-1763)

Felicia, a feminist therapist, endorsed some degree of similar concern that psychological models not categorize women. At the same time, she related that she felt that research and a focus on women was important, because psychology traditionally has been androcentric and not understood women very well (1150-1190). In sum, these participants expressed a concern that an appreciation of sociopolitical and gender issues should not be allowed to totalize and marginalize women and override their individual concerns.

*Categorizing women as victims.* A more specific concern about the categorization of women pertained to the idea that feminist theories might limit women by encouraging them to inappropriately externalize blame, become stuck in unresolved anger, and categorize themselves as victims. Nine participants raised this concern about a highly politicized approach to therapy with women. Participants were concerned that, by de-emphasizing the issue of individual complexity and responsibility, a gender and power-focused approach could inadvertently harm

clients by taking away their motivation to exert their own personal control. Xavier, for example, noted that he felt that an individualistic focus on personal responsibility led to increased client effort and actual movement and change and was beneficial for clients in most situations (52-76). Brian expressed concerns that a sociopolitical model of women's distress might provide individuals with a "groupwise excuse" for their problems (1624-1631). Kathleen, a psychodynamic therapist working in private practice, responded to a question about relation of gender and power to women's distress by warning that "...blame is for God and little children..." (62). Nadine raised concerns that the emphasis on sociopolitical explanations used with female clients in her organization often led them to see their lives as "fatal", "scripted" lives, and did not adequately encourage them to take personal responsibility and control (819-843). Similarly, Jane noted:

> Jane: I don't know if this will make the point, but we often get people on the psychiatric unit, women, who will come in, and maybe they have borderline personality disorder, or whatever it might be...I'm not sure if you should call them that, but, you know, if they are diagnosed with that. Really suicidal, self-destructive, and acting out a lot and that sort of thing. And when you talk to them, or when you talk to some of the staff, they will want to pin everything on sexual abuse, for instance.
>
> HG: Really?
>
> Jane: And, you know, it certainly is a hot topic, you know. Could be one of those contextual things, maybe that...It's in the media, and are they taking that from the media? It's one of the things you don't know. And when you get them to try to be specific, some will recount maybe one incident with a little boy down the block. And they will pin that whole way of behaving, and their pathology on that. And there is a tendency for some other staff members to really glom onto that, "Oh! This is really important! It explains everything!" And I think that this is very risky. It is a very risky approach to take, and I think that this is one of the risks of getting into a really, a gender-focused kind of, politically-driven....I don't know if I should say politically correct-, or whatever, driven kind of understanding of somebody. That you can miss a whole lot of other things going on. But yes, it is a terrible thing and there are cases, obviously, where there has been absolutely profound sexual abuse, and it has been serious, and it has shaped the person, and you know

> it. But these other cases, where someone will grab onto this to make sense of what's going on, or sometimes to excuse their acting out behaviours and all of that, and that is really inadequate in helping them. And it is very risky, so I think that you have to be very careful how you think about those things. Does that make sense?
>
> HG: It does. So it's something you have to watch that you don't get carried away with.
>
> Jane: Yes. It's not a simple answer. And I think that we can easily do that with women's issues.
>
> HG: So what kind of a perspective should this information be kept in?
>
> Jane: You kind of have to go back and forth between the individual's processes that they're presenting to you, and how they interact with you, and what you observe about them, and how they interact with you, and what you know about the specifics of their own background, and then these other issues. (381-460)

Laura, Grace, and others (Chris, Adam, Theresa, and Xavier), voiced similar opinions. For example, Laura noted that she thought that some feminist therapists seeing couples could assume that the male partner was causing problems in the relationship while failing to notice the woman's role in their difficulties (762-776). Similarly, Grace described her perception that some feminist counselors might downplay or fail to recognize that women are aggressive or oppressive toward others (513-545). In addition, Theresa expressed concerns that a feminist explanations and interventions might potentially lead clients to become stuck in unresolved anger:

> Theresa: If I'm a so-called feminist therapist, and I have a lot of unresolved anger, then I'm going to harm people.
>
> HG: Do you think that that is the case for feminist therapists?
>
> Theresa: Oh, if looking at the context and understanding all this, in the end, makes me really angry at men, and unable to relate to, or deal with men, then I'm really stuck, right? I mean, that's half the world's population. It's causing the opposite problem [to self blame].
>
> HG: You think that women sometimes become angry in the process of therapy?

> Theresa: Oh, yes, obviously. I don't think it's anger that's the problem. I think getting stuck in it, having unresolved anything, any kind of problem, is the problem. I don't think anger, any emotion is unhealthy, as long as what it is, I am able to use it both as a signal, and as a way of energizing myself to interact in a more effective way. But when I get stuck in anything, when anything is unresolved, I get stuck, then I'm worse off.
>
> HG: Are you saying that a feminist approach would be more likely to end up in unresolved anger, or...?
>
> Theresa: I honestly don't know what that approach it. I really don't know what it is, but I think the fact that...if I get an extreme view of anything, and it is based on unresolved issues within me, then I am a danger to a client. And I don't want to be a danger...I don't believe anything in the world is the final answer for people's problems...(2000-2067)

Overall, in criticizing sociopolitical approaches to therapy with women, participants emphasized approaches that placed more focus on helping the individual to see their own power, strength and responsibility.

*Summary: Reservations about emphasizing sociopolitical explanations and consciousness-raising.* Several participants in this sample, including some who described themselves as influenced by feminist models of distress and change, described having concerns about the extent to which some forms of sociopolitical models were allowed to guide therapy. Overall, many participants defined therapy as a predominantly individual- and intrapsychic-focused process. They advocated following the individual by careful, comprehensive assessment and an individualized approach to therapy which emphasized individual insight and personal agency and responsibility. Some also characterized this process as relatively value-free. Sociopolitical models of women's distress, in contrast, as well as the consciousness-raising techniques following from them, were sometimes seen to violate the therapeutic rules of individual focus, avoidance of imposing values, and the emphasis on client agency and personal responsibility. While not

opposing the importance of understanding the role of social power in women's distress in an absolute sense, some participants expressed views that some feminist therapies were vulnerable to dogmatism, authoritarianism, and the promotion of blaming, victim roles which stripped clients of their agency. In this way, feminist approaches in therapy were perceived to risk failing to provide appropriate and sufficient treatment to clients. The technique of didactic consciousness-raising in particular appeared to raise concerns, and some participants with concerns about losing the individual advocated de-emphasizing sociopolitical models or using sociopolitical approaches which were less direct and didactic and more focused on client-centred, egalitarian relationship values.

*Concerns inspiring the use of a sociopolitical approach: problematizing an individualistic focus.* In contrast to views that a sociopolitical approach should be downplayed to avoid losing the individual, a smaller number of participants framed therapy as inherently political and problematized psychology's intrapsychic focus as harmful to women. They also indicated that their concerns about the personal and social repercussions of an individualistic approach inspired them to utilize sociopolitical techniques, which sometimes included consciousness-raising, with female clients. In general, participants contributing to this theme emphasized that a noncontextualized approach in therapy might lead therapists to lack empathy for clients or unfairly imply that clients are to blame for their difficulties. They also emphasized what they perceived to be the beneficial results of focusing on women and incorporating a sociopolitical analysis in clinical work with female clients. These perspectives, and their relationships with the sociopolitical techniques described at the beginning of the Results section, are outlined and summarized below.

*Focusing on the individual/intrapsychic is insufficient.* Felicia, a feminist therapist, noted that, "I think when you get to the point where you think that it's enough to be Rogerian, or to be CBT, or whatever it is, then that's problematic." (1280-1287) She and six other participants expressed views that in at least some areas, psychology typically has not paid sufficient attention to the experience of women. Felicia advocated for specialized research and clinical work that focuses specifically on women's experience on this basis (1170-1190). Other participants reported that the lack of attention to women's experiences and women's context has led to treatment efforts that are not sufficient for women. Although she reported that she was wary of taking a gender or sociopolitically-focused approach in treatment, Diane also described her frustration with students who lack knowledge about broader social and other factors influencing individuals' distress:

> I think psychologists should need to take other courses besides psychology. Because I think that sometimes, we get too narrow in psychology. Too individualistic. Even though, I don't think that it necessarily changes the one on one work that you do with people, but I think that as a psychologist, if you have a broader perspective, and try to understand the context of where a person lives in society, I think that it can help you feel more in tune, to be more empathic in a genuine, rather than a manufactured kind of way. So in psychology, I think we should do more than that. It really bothers me when somebody comes out with a degree and it's all in psychology. I think that we should have a much broader range in terms of sociology, and English Literature, and a broader base so that we can think through things on not just an individual level, not just an intrapsychic one. It would influence how supportive you could be, things you would normalize or not normalize. (1089-1139)

Likewise, Xavier described that his background training did not prepare him sufficiently to appreciate gender issues, and noted that this hampered his ability to understand and reach some types of female clients whose distress had a strong gender/cultural basis:

> I mean, I come from a traditional sort of background, and one didn't think about these things, you know, in the way things were...techniques were defined, techniques were applied, at the time, at least in the adult area, the huge majority by

> male therapists and theorists. You know, all the major established therapy on anything have male origins. I mean, there was always Anna Freud, but she was the exception rather than the rule. But that meant that, perhaps to this day, that a lot of theorists have been men, and one didn't particularly think beyond the theory about the causes of one's distress in a treatment situation. And as I am a traditional male, I found it very difficult to understand, for example, why women would stay with these partners who were just creeps and stuff like that, and do things that most men wouldn't do. So one didn't have a lot of success with these sorts of clients. (4-24)

Yvette voiced a similar opinion about the dangers of insufficient treatment:

> ...there are people who tend to make misattributions or even dangerous kinds of mistakes. For example, one of the things that we see in this population [university counseling centre] is women who have had experiences of coercive sex. I think that, for example, people who didn't have an understanding of the power differential in some kinds of male-female relationships, or who didn't understand notions of sexual assault or coercive sex, would miss the traumatic aspect of the person's experience and would miss the coercion and wouldn't treat the person as having been sexually assaulted. I don't think that you need to be steeped in the literature to see that, but I think that some of it helps to notice those kinds of things. Or you just might see the person as depressed and needing medication. Rather than someone who's been oppressed. (765-789)

Similar to other participants' concerns that a sociopolitical approach may obscure a complex picture of the individual, these participants argued that a lack of awareness of issues of gender, power, and distress can lead to the insufficient or improper treatment of female clients.

*Lacking empathy and blaming women.* A number of clinicians perceived a lack of awareness of the sociopolitical aspects of women's distress to be a potential hindrance to empathy with clients. Diane's comment, presented earlier, is a case in point. One perceived consequence of a lack of empathy stemming from an underappreciation of women's issues is the blaming of women. A number of participants expressed concerns that without some acknowledgment of the contextual issues that have an impact on women's distress, clinicians may blame female clients, female clients may blame themselves, and women's experiences in general may be dismissed or

denigrated by clinicians. For example, talking about a client she saw in long-term therapy, Theresa described:

> ...my sense was that he [the husband] was emotionally abusive. But I can't be sure, because I didn't really see him. And a lot of the time she tended to behave that way toward herself as well, and it kept her depressed. But she went to a psychiatrist and he said to her, "Look, you don't understand how bad it is for a man to have a depressed wife, and that's why it is your fault that your husband doesn't spend much time with you, and that he's away, and that he spends so much time at work!" And it really fed into what she'd come in with. But I thought that that was a very male dominated, patriarchal explanation of all that was going on. Very difficult for her to struggle with. There was a lot of blame in that context already, and it came from her family, him, the psychiatrist, herself. He'd said, "Your poor husband, what he has to endure!" And it was very hard for her to grapple with that. A little later on, it turned out that the husband was in trouble for doing something illegal at work. And that was why he was spending so much time at work, so the psychiatrist's explanation didn't really hold there...(345-373)

Quinn also talked about this issue. In her interview, Quinn noted that traditional psychological models tended to be based on unrealistic notions of personal power and free will that many of her female clients, especially single mothers and sex-trade workers, do not have. Talking about her concerns about the impact of a non-socially aware approach to women and therapy, she said:

> I think that where the problem comes in [with an approach that does not consider gender and power] is when you perhaps inadvertently convince the individual that the social problem is their problem, or convince them that they must do something, or that they have the ability to do something that they realistically do not have. To take on a societal problem as if they have free choice when they don't have free choice. I think it's to double bind a person to the point where they feel even less competent than they did when they walked in the room. (488-501)

Felicia noted that the blaming messages that can be part of a non-socially aware approach can also serve a status quo that ultimately does not serve women:

> If it's not socially conscious therapy, then it's relaying a message to the person that this is about you, and only you, and so fit yourself to society. It's an unquestioning approval of the way society works, too, and I've seen it a million times in a number of different settings. (797-810)

In contrast to participants who suggested that women often already know about sociopolitical issues impacting on their distress, Paula noted that women often do not fully appreciate the extent to which their lives are constrained within society (851-854; 941-944). Giving examples of her work with women who have been sexually assaulted, Paula notes that women often blame themselves and so it is sometimes her job to discuss dangers and blaming messages they get from society (941-949; 829-851).

Three participants also noted that they felt it was important to incorporate a sociopolitically-aware approach to therapy because women's experiences have tended to be denigrated or discounted. Talking about the importance of having women's mental health programs, Ellen stated:

> I think that when you don't have an overt appreciation of those issues, even if they don't make up 50% of the variance, if it's even 20 or 30%, that's still a very significant impact and women certainly have had the experience and I think continue to have the experience where their reality is denigrated and discounted by interacting with people who don't have an appreciation of these issues. For example, and again, to look at my gay clients as an example, I've had numerous examples of gay clients who have met therapists who wanted to treat them out of their homosexuality. And this is the new millennium, but it still happens. And I think women's experiences are similar. We still get women who have seen mental health professionals who are old battle horses who are just kind of astonishing, but it still happens that they say that you should be fulfilled by having a husband and children, or you're not having the right kind of orgasm and that sort of thing that you thought had gone out 30 years ago. It's still in fact there. So, without some pretty strong countervailing ways of doing things, that still exists. Hell, I had a big fight when I was at X hospital less than five years ago with a psychologist who made the comment that being gay was nothing more than just a lifestyle choice. It has taught me, much to my surprise, that there are some unreconstructed, old-fashioned, fairly primitive ways of thinking that are still out there... (363-425)

In a similar vein, Victoria claimed that she attempted to ask about and legitimize women's issues (such as the impact of menopause) because of her concern that these experiences are often discounted (93-129). Likewise, Theresa notes that she encourages women to talk to one another

in order to help them rise above certain dominant cultural discourses that frame women as inherently "weak"(203-237). In the excerpt below, she also discussed the larger social control outcomes of failing to address issues of social context in therapy with women:

> Theresa: I think that women connecting with other women is a very important part of this.
>
> HG: How so?
>
> Theresa: Well, it helps them to understand that their thoughts and concerns aren't just uniquely theirs. It helps them to explore new contexts, and maybe to look at things differently. So that they don't feel it's just them, and so they don't just accept the...the more traditional, culturally determined explanations of their lives and what's happening to them. We need to get them to explore other perspectives.
>
> HG: Dominant explanations?
>
> Theresa: Well, a lot of the explanations would be that...women are more prone to depression because women are simply weaker. Or that certain diseases are diseases of women. An interesting thing for me is that Valium was first put out by the company as a good remedy for the housewife's complaint. Make her feel better. They called it "the housewife's complaint", and thought Valium was a good remedy for that. So that's part of the cultural context. Women are not supposed to complain. Women are not supposed to be angry. They're not supposed to do any of that. So that was the housewife's complaint. Being anxious, depressed. So the drug company was saying to physicians that they'll complain less if you give them this, they'll feel better. To go back to being what they should be. And that's documented. It was a prescription for a bigger social thing that was going on. And if you are depressed, often you might go to a physician or psychiatrist and get something not to be depressed, but they won't address those larger issues. Maybe that's starting to change, but not entirely. (200-284)

In sum, participants emphasized that their wish to avoid blaming women, an unintended effect of nonsocially aware treatment, motivated their incorporation of certain techniques, particularly consciousness-raising techniques in their work with women.

*Benefits of focusing on women and the social context.* A few participants who tended to think and interact with clients in a more sociopolitically-aware manner than was typical also

emphasized the important benefits of focusing on women in research and therapy. These benefits were in addition to the previously described benefits of enhancing empathy and reducing self-blame, and center on the idea that understanding women will ultimately help men and women, psychology, and society in important ways. Felicia noted:

> I think that the more that we know about women and what women go through, the more we'll understand about men, and human psychology, and relationships, so...I think we need to do it all and studying women is an important part of that. (1179-1190)

Similarly, Steven noted that empowering women can ultimately have a positive impact on men's well-being:

> I will tell you an interesting little tidbit. There's a book by Terence Real. It's about covert depression in men. It is really interesting. One of the things he said in there is, "When I have a depressed woman in therapy, I empower her. When I have a depressed man in therapy, I empower his wife." Think about that. I think it's very much a gender statement. What he means is, that when women get depressed, it's because they are disempowered. They need more control in their lives. When men get depressed, his theory is that a huge amount of depression occurs in men, but gets acted out. We often call depressed men violent, alcoholics, abusers, and so on. And what he says is that a lot of it is covert depression. And so, by empowering women, it forces men to deal with the truth. I think it is a gender statement. I think it is very interesting. (1305-1338)

In contrast to some of the negative constructions of feminism as involving a blaming attitude that is insufficient and disempowering for clients, Theresa noted that her goal in discussing contextual issues related to women's distress is not to blame and deny agency, but is in many ways an attempt to stop women from paralyzing themselves with blame:

> ...talking about the context is not necessarily about blame. Context is understanding. So that tells me that the person is thinking about blame. So if you don't blame the context, are you going to blame yourself? Do they [therapists who are reluctant to discuss issues of context] want the person to blame themselves? I think they do, you know? So what if you don't have to blame the context, you don't have to blame yourself, but you have a broader understanding than you had, and you have more choices. So that's what I think. I think that people who don't want to look at context are thinking a lot about blame. (646-659)

Likewise, Felicia disagreed with views of more traditionally-oriented therapists that feminist therapy tends to involve distracting individuals from their own goals in favour of attending to the therapist's agenda. Describing her reaction to stereotypes about feminist therapy, she expressed the opinion that feminist therapy that involves consciousness-raising can attend to both personal and political issues and be attuned to the needs of individual clients:

> Yes, that's what people think, right? It's that you're being irresponsible, and you're placing your agenda above theirs, and you don't want to take people away from their experience and distract them. I don't think that it has to be either-or. I don't think you have to choose. I don't think that you have to say, "Well, should I take a social analysis or do I stay with the client's emotions? And the answer is you can do both. I try to do both. I do think that timing is important. If someone is in a lot of distress, I don't move in and say something like, "Are you aware of the percentages of women..." Of course not! But, at some point, later, you may say something like, "So many women share these sorts of stories with me..." And that's a pretty gentle way of being socially conscious, isn't it? And I think it's really important... (936-989)

Felicia (1359-1459), Margaret (1169-1291), and Quinn (168-179) also expressed views that feminist therapies encouraged client agency rather than stripping it from them, a concern held by some who believed that sociopolitical models of distress might promote the assumption of a victim role. In sum, beliefs about the benefits of a focus on gender and societal issues, as well as more positive views of sociopolitically-informed therapy, were associated with endorsement of an incorporation of these issues in one's clinical approach.

*Summary: Concerns about not focusing on women and society.* Overall, a subset of participants expressed beliefs that not taking a sociopolitical approach into account in therapy with women can harm clients. This is essentially the flip-side of the concerns about sociopolitical therapy outlined earlier. Failing to focus on women, gender and social power was believed to ultimately blame clients and fail to question or challenge a disempowering status quo within

society. In addition, some participants endorsed more positive views of feminism and feminist therapy than was the case amongst therapists who advocated a downplaying of the influence of sociopolitically-based models of women's distress. Some participants in this category linked their concerns about noncontexualized therapy and their beliefs about the benefits of focusing on women as the inspiration for incorporating the techniques described at the beginning of the Results section. This included, but was not limited to, explicit consciousness-raising efforts, which were otherwise much criticized by participants. Table 3 presents individual participants' reporting of concerns both pro- and con- the use of therapeutic models which frame issues of gender and power in a fairly central manner.

*Other Factors Influencing the Use/Shape of a Sociopolitical Approach in Therapy*

The focus on the individual in therapy, with its' related concerns pro and con a sociopolitical approach appeared to relate to many therapists' views, and to differences in participants' incorporation of a sociopolitical approach in therapy. This theme, however, was also not sufficient to explain all clinicians' perspectives with regard to the incorporation of a sociopolitical analysis of women's distress in clinical work. Some subjects, such as Xavier, for example, expressed support for sociopolitical models, problematized psychology's apolitical focus, yet reported that a sociopolitical approach did not have much influence on his work. In this last section, I describe a range of additional setting, client and therapist factors that may impact the use and shape of sociopolitical techniques in therapy. These themes were derived from participants' descriptions of the influences on their own approach in therapy and their perceptions of the factors which are relevant to other clinicians assuming a gender and sociopolitically aware stance in therapy. Some of the factors above relate to and interact with those described earlier.

Table 3.

Participants' Views About Focusing on the Individual in Therapy

| Name | Concerns About Losing the Individual | Concerns About Individualistic Focus |
|---|---|---|
| Identifies as Feminist Therapist, Feminist, or Specialist in Women's/Gender Issues | | |
| Ellen | X | X |
| Felicia | X | X |
| Laura | X | X |
| Margaret | X | X |
| Oliver | | |
| Paula | X | X |
| Quinn | | X |
| Steven | X | |
| Theresa | | X |
| Victoria | | |
| Wendy | | |
| Yvette | | X |
| Does not Identify as Feminist Therapist, Feminist, or Specialist in Women's/Gender Issues | | |
| Adam | X | X |
| Brian | X | |
| Chris | X | |
| Diane | X | X |
| Grace | X | |
| Henry | X | |
| Ian | X | |
| Jane | X | |

table continues

| Name | Concerns About Losing the Individual | Concerns About Individualistic Focus |
|---|---|---|
| Kathleen | X | X |
| Nadine | X | X |
| Robert | X | |
| Xavier | | X |
| Zoe | X | |

For example, the factor of education related to positive perceptions of feminist therapy, described earlier. Client factors (such as a diagnosis of borderline personality disorder) were also associated with increased concerns about imparting a victim message. These interactions will be noted where appropriate. Compared to the other themes described above, some of the factors below were based on relatively smaller portions of the sample and hence the relationships described should be thought of as more tentative and in need of further exploration At the same time, however, they offer intriguing ideas about the wide range of influences that shape a sociopolitical approach with female clients.

*Setting factors: organizational mandate and climate for feminist work.* Seven clinicians in the sample reported that work setting factors, including the organizational climate, organizational demands/mandate, catchment population worked with, length of time available for treatment, and format of therapy (individual, group, couple, or family) related to their use of sociopolitical models or techniques. Some participants suggested that the organizational climate and/or the mandate of one's work setting is related to a focus on sociopolitical factors in therapy. A few, such as Nadine, Jane, and Xavier, described that some workplaces put little emphasis on issues of gender and power. Nadine noted that her work in a forensic setting in which in-depth, extensive assessments are required by courts led her to consider more contextual factors than is often true of other professionals. She speculated that this would result in her being somewhat less likely than others to blame individual clients (1301-1369). Although Nadine's evaluation of factors such as poverty, abuse, and other contextual issues in her clients' lives could potentially set the stage for the incorporation of sociopolitical techniques, however, the mandate of her organization, characteristics of its clientele, and the short length of treatment time available often meant that sociopolitically-guided techniques other than advocacy and connection with community agencies

were often not emphasized. Instead, Nadine described her focus as that of helping clients achieve basic stability and day-to-day coping strategies to avoid reoffending. She perceived therapy involving consciousness-raising about issues of gender and power to be a relative luxury for clients who are struggling to meet basic needs. She contrasted the work required within her own organizational setting with the greater freedom possible in a private practice therapy setting, where clients may have more resources and receive open-ended treatment in which they determine the goals:

> Nadine: You know, probably outside of the forensic system, I'd see a woman who are presenting as upset, and I might want to understand how her gender has limited her life and why that might be a source of her distress. But here, um, you have only a relatively short period of time to work with her, and so it's a luxury. The thing is, it's not just a luxury, it's that we have to be very, very relevant. It's critical. There are other factors that are more pressing. I just see a lot of women who have very, very overwhelming life circumstances. And I think that in a private practice setting you would be more likely to see women in the position of being dissatisfied in their lives..." (1586-1610)
>
> HG: So...in private practice...
>
> Nadine: Those things would be more likely to come up, be linked to issues of gender and power, so you could address them. Because the baseline of whether you've done a good job is whether your client tells you that she feels better. The baseline for us in determining whether we've done a good job is whether she goes back to prison or not.
>
> HG: So your role and goals are very determined by what your job is, and what the system needs.
>
> Nadine: And who the client is. The client in a forensic setting is not the offender. A lot of offenders don't want to see us, although the women are definitely more open. But the client is the community, the potential victims. And you always keep that in mind...It's clear that although you have a humanitarian interest in helping them, the goal is to keep this person from ever harming anybody else again.
>
> HG: That's always at the forefront.
>
> Nadine: Uh huh. So I think that probably the focus of a private clinical setting would have the luxury of involving a gender analysis. (1712-1761)

Working in a middle-class private setting, however, was also described as not conducive to incorporating a sociopolitical approach in therapy. Jane, a psychologist working in outpatient hospital counseling service and private practice settings, noted that in a middle-class environment, issues of gender and power did not often seem central:

> HG: You mentioned political factors....Do you think that political factors...I don't know whether you want to call it power or status women have in society...do you think it has an effect on their psychology, in the distress you see? Is that a useful way of thinking about it for you?
>
> Jane: I don't tend to approach people in therapy from that viewpoint, although partly that's because of the people that I have tended to deal with. You know, more the Caucasian population, you know, middle-class or more. I think that if I were dealing with a different population that that might be more salient....because I certainly think that it is for some women, you know, being disadvantaged, oppressed.
>
> HG: Yeah, okay.
>
> Jane: But, because of the nature of my practice, because of where I have worked, it's just not that much of an issue.
>
> HG: To see people who live in the suburbs, they have so many more resources.
>
> Jane: Yeah. But yes, I think that it is a real factor for some women. For many in the world it is a real factor, actually. Maybe not so much in our culture, although some people may disagree strongly with that.
>
> HG: So especially when you look at people from other cultures.
>
> Jane: Yeah. (554-599)

For Jane, gender and power were seen as less relevant when working in middle class settings, and were anticipated to be more salient in settings serving individuals of other classes and cultures.

Xavier speculated that the problem-oriented and individual mandate that is traditional in a symptom-focused clinical health psychology setting can stand in the way of seeing gender as an important issue:

> Xavier: And I think that it also has to do with what area you work in. I work in clinical health psychology, and the techniques in that are traditionally male-originated, male-oriented techniques. They were developed by male therapists. Do you know what I mean? In that sort of original group. It's oriented toward self-control...it's applying yourself in a fairly individualistic way...to develop self-control. And to expect the world to fit in with your efforts to do that. (169-179)
>
> Traditionally, in health psychology, it's a symptom-focused treatment. So if a person comes in with a physical symptom or set of symptoms, then your job is to help them deal with that. These ways do not involve discussion about sociocultural, historical kinds of things. Whereas one of the talking therapies might well. So health psychology in general, might not make much use of its importance. There is another whole branch of health psychology that does deal with that. Women's health. (239-252)
>
> HG: So what you're saying is that...the area in which you work, in health psychology settings, as opposed to a more interpersonal therapy...you pay more or less attention to those kinds of social and cultural and gender issues? So the demands of the setting would influence the degree to which that is helpful or useful?
>
> Xavier: Sure. (259-268)

Other participants indicated that they felt, on the basis of personal experience or perceptions of other's experiences, that certain organizational settings would place more emphasis on a sociopolitical analysis. Grace, Felicia, and Margaret indicated this. Contrasting her own practices with that of others, Grace indicated that in her experience, sexual assault centres tend to involve more radically political counseling:

> I'm thinking to myself as compared to some of the women who work at some of the sexual assault centres, and I don't want to stereotype, but some of the centres seem to be extremely radical in their beliefs and practices about women's treatment. And if I were you, I'd talk to them... (513-522)

Felicia noted that her work within a women-centred organization influences her work with women. She notes that she received referrals on the basis of her expertise on women's issues (1308-1313), and described:

> I'm so lucky now. I work in a feminist environment. I have like-minded colleagues. I think that it could be very isolated and you would have a lot of self-doubt if you didn't have support in trying to figure out how you could integrate feminist views in therapy. Certainly many of the places I've worked at have not been feminist, and it has been a fight to vocalize my opinions and I experienced some self-doubt about, you know, "What am I doing? Am I being helpful?" in my early years. And it can be a very isolating and demoralizing experience if you don't have support to let you know you're on track. (641-661)

Similarly, Margaret noted that she worked within a community health centre with an overtly multi-cultural, community-focused and empowerment-oriented mandate. This climate generally supported her efforts at incorporating a politically and gender-aware approach.

*Client factors.* Other clinicians noted that certain client factors would lead them to see gender-related sociopolitical factors more or less clearly or to emphasize or de-emphasize certain sociopolitically-based techniques. The client factors which emerged most frequently in interviews with participants included the client's level of distress and ego functioning, the client's level of knowledge/awareness of women's issues, and the perceived relevance of the client's concerns to a sociopolitical analysis of women's distress.

*De-emphasizing consciousness-raising with distressed and 'borderline' clients.* Eight participants (Jane, Diane, Nadine, Theresa, Yvette, Ellen, Grace, and Zoe) indicated that the client's level of distress and ego functioning would influence whether they perceived a highly sociopolitical conceptualization or overtly political techniques to be appropriate. These participants generally noted that sociopolitical techniques such as consciousness raising, may not be appropriate for individuals who are in acute distress, face overwhelming stress, have few resources, or are chronically disorganized. This did not necessarily mean that a sociopolitical approach was unimportant to participants, but rather that it was not seen as the first order of business. Nadine's earlier comment that her work with highly overwhelmed women with few

resources would lead her to focus on more immediate and basic life concerns is a case in point. Felicia similarly noted that she would not step in with didactic consciousness-raising with a highly distressed client. The view that consciousness-raising was not appropriate for highly distressed individuals was also reflected in Grace's comment, presented below. To her, a sociopolitical approach would come later in therapy:

> I mean, there's a time and a place for everything. If someone's in acute distress, you'd better deal with that distress right away and leave the analysis for another time. So sure, there's always timing issues. Um, and sometimes that's a matter of introducing a thought and if it goes right by them, well that's maybe a hint that let's not go there right now, and another time. But if a person's in acute distress, I'm going to focus on coping techniques so they can get through the trauma of the current moment, and I'm not going to be saying, "You really should look at how you're running your life!" That wouldn't go over very well. Besides which, I'd like the hour to end. I don't want them to be a puddle on the floor! "Oh no! Not only am I a mess, but I'm a doormat! Things were bad enough when I came in! (579-604)

Yvette, however, noted that she might actually become more direct and didactic about issues of abuse with distressed clients if she felt that they were in an imminently dangerous environment. She noted that whereas she may employ a more questioning approach with individuals she suspected were in abusive, but not in immediately and highly harmful environments, she would be more likely to intervene directly and strongly label events as abuse if the risk of harm was greater (511-521).

Three participants in this subgroup also suggested that they might be less likely to do consciousness raising with clients with certain defensive and self-defeating personality structures. Diane, Ellen, and Jane noted that they might be more reluctant to do consciousness raising with individuals who are disorganized and acting out for fear that they might reinforce the maladaptive defensive structures these individuals already possessed. For Jane:

> Jane: Part of it...part of what it is getting a feel for their overall functioning in the first place. Their intactness. I mean, obviously some people are, personality wise, stronger and they are more intact, you know? And when they are kind of at that level, and there does not seem to be a great deal of [personal, intrapsychic] pathology there, then I'd be more likely to think, what is going on more in a social context here with this person, you know? If they come in and they are really functioning badly, and have a history of functioning badly, I think I tend to look more at internal, individual kinds of factors.
>
> HG: And if they seem to be more high functioning...
>
> Jane: Then you look more at the external stressors, including some of the broader social stuff. With the person who is very low functioning, you're working on so many things...just shoring them up in some cases... (508-547)

In a similar vein, Jane also described that she felt more inclined to assume a more consciousness-raising approach with a young female client with an eating disorder due to her sense that she was still "young and malleable" (499-506), rather than exhibiting a more entrenched and chronic form of psychopathology.

The perception that consciousness-raising might also reinforce some clients' maladaptive defenses is also implied in Diane's comments. As she talked about the issues of women's status and why she typically does not take a consciousness raising approach, Diane noted:

> Diane: You know, one of the themes that comes up with women, but again, may be because we just don't see as many men, they tend to see themselves more as victims. And I don't know whether we tend to encourage that somehow, subtly. It's central to some forms of personality disorders, for example, borderline personality disorder. Seeing themselves as victims of men, that men have done these things to them. I don't sense that as much from men, that they talk about their problems as though they're the victims. Not as much as women. It's still there, but it's much more obvious amongst women.
>
> HG: Do you think that...feminist...whether that kind of a philosophy has kind of promoted that kind of helplessness?
>
> Diane: Right. That something has been done to you or taken away from you. It's a theme that pervades their way of being and looking at their life. I don't see it as much with men.

HG: You mean a defensive stance?

Diane: Well, sometimes they don't realize how they contribute to their own difficulties or how they could decide things differently or how they could take control in some of the decisions that they're making. Particularly in relationship to men.. (1256-1318).

Ellen went further:

Ellen: I think there's a slightly different question, which is, does a sociopolitical interpretation ever get in the way of things? I think that actually, it is possible for...I mean, you do see neurotic and defensive personalities, especially among our more borderline clients. Where you know, sometimes sociopolitical explanations, like many other explanations, are sort of used as a club to beat other people with or to excuse the self and so on like that. You know, "I will never have a satisfying job because I am female," and "The cards are stacked against me," and so on and so forth. So, you do get that sort of thing where you feel sort of wary...

HG: You mean they come in saying that?

Ellen: Yeah, sometimes. Or, well, the reason that I am saying that is that I've got a client who has...she does that with everything. She says, "I can never be happy because I can never have children. It's too late for me..." She's very black and white. I mean, that's true, and there are some socialization issues that are relevant to that. But I'd also say that the real reason she can't be happy is that...she has a borderline personality disorder with very poor coping skills, impulsivity, hostility, aggression, you name it, she's got it. And she's a real pain to be around. But the issues are not so much the socialization ones, but, for lack of a better word, the acting out behaviour that just becomes another aspect of their neurotic behaviour.

HG: So...you said, they may be likely to use a sociopolitical interpretation to rationalize or defend or excuse themselves?

Ellen: All of that. Whatever way makes sense at the time in terms of their dynamics.

HG: So...what effect does that have on your approach? Are you saying that you would be more...cautious?

Ellen: Yes, well, I'd likely explore those issues with them, but I probably wouldn't see that as something that would be...primary. Oftentimes the primary goal in therapy with borderlines is setting reasonable limits and containing the behaviour. So sometimes going down that road...It's sort of like someone with paranoid delusions. I'm not saying that borderlines have not been victimized by using that metaphor, okay? You can talk about them therapeutically to some extent, but you

> have to be careful that you aren't reinforcing those delusions. Sometimes some of these statements may come across as sounding cynical, I know... (626-645)

In sum, a subset of participants in the sample noted that the client's level of distress and ego resources would influence their use of consciousness raising techniques in therapy. Amongst the individuals who raised this factor, all but one indicated that they would downplay a consciousness-raising approach amongst clients who were acutely distressed, in need of more basic help with meeting life's demands, or prone to using such interpretations in an ultimately self-defeating manner. The exception to this approach was related to one participant's sense that labeling abuse would be imperative in situations in which clients were at imminent risk of harm.

*Gender and power are more visible in group/family/couples therapy.* Three participants reported that group, family, or couple modalities of therapy were more likely than individual therapy to bring issues of gender and power into relief. The greater visibility of gender and power issues in group, family, or couples contexts were linked to greater attempts to include discussion of these issues with clients in therapy. For example, Diane perceived that consciousness raising would be less meaningful in therapy with individuals as compared to groups. She noted:

> As far as individual work goes, I don't [look at/talk about gender/sociopolitical explanations of women's distress]. At least, not in any direct way. Maybe in passing. I think that that may be more appropriate for group work, for a group that looked at eating disorders, or so forth, to look at that part of it, cultural kinds of things. I guess a group can share that more. (593-607)

Similarly, Steven noted that although he did individual work, gender and power issues were often brought into highest relief in couple and family work (727-735), a view also shared by Henry (415-537). In general, a number of participants felt that issues of gender and power were most salient and meaningfully addressed in therapy that involved multiple clients.

*The client's awareness of gender/power influences the therapist's emphasis on consciousness-raising.* Another subset of six participants (Diane, Laura, Margaret, Ellen, Yvette, and Oliver) indicated that the importance of a didactic, consciousness-raising approach in their work would be related to their sense of a client's awareness of gender and power issues. Diane (608-614) and Laura (514-531) noted that because they perceived women to be aware of issues such as double standards for male and female behaviour and unrealistic social pressures about appearance, therapy does not need to focus on this content but is rather the appropriate forum for understanding individual dynamics involved in their difficulties. Margaret varied the frequency of consciousness-raising to her client's level of knowledge, while Yvette noted that she tried to engage in overt didactics about issues such as power only when clients had no knowledge of the issues and were asking to be informed (340-363). Oliver also noted that his consciousness-raising efforts are guided by his perception of a client's level of knowledge:

> ...sometimes it really is new information. That depends obviously on the level of life experience, sophistication, education...At the front end, I, with anyone, regardless of level of education or life experience, take a more proven and conservative approach. I don't let myself make many assumptions that because they have an MBA or whatever, that they must know certain things. So I see myself as someone who needs to bring in, in the sense of validation, our experience, in a social norm sense or a social learning sense, and how it fits in... (508-523; also 1042-1122).

Similarly, Ellen reported that she sometimes brought up issues such as gender-role socialization because she feels that clients may not be aware of them, or may not be aware that these issues have a link to women's distress (242-261).

In sum, the client's perceived level of awareness of women's issues guided the extent to which this information was brought into sessions. For some participants, the sense that clients already possess this awareness leads them not to focus on it in a didactic manner. Others brought it up in

sessions due to concerns that clients may not know about these issues or not be aware that they apply to their particular concerns.

*Following the client's emphasis and interests.* Some participants (Felicia, Adam, Brian, Jane, Steven, Margaret, Yvette) indicated that the client's interest or receptivity to in discussing gender issues, or their evaluation of whether the individual's problems had a sociopolitical basis would influence the degree to which they brought up these issues in therapy. Felicia , Margaret, Steven, and Yvette described following the client's lead focusing on gender issues, noting that their focus on sociopolitical or gender issues would be related to the client's interest in discussing these issues. Steven related that he also follows the client's lead in knowing what to focus on and emphasize:

> I think that gender is sort of an inescapable factor in life. So is it always useful? Sometimes. You can tell by really listening. It's like, if you do good therapy, they lead you. They'll bring it to you. You just follow their trail, and you eventually get to what's important...(1264-1282)

Others participants described incorporating consciousness raising on the basis of their decision that sociopolitical issues are somehow relevant. For some therapists, the clue as to relevancy sometimes stemmed from the fact that the client's concerns were more stereotypical women's issues such as sexual abuse or eating disorders (Felicia, Jane, Adam). This pattern was also accompanied by a weighing or ruling out other possible causes in relation to a gender/power explanation:

> ...there are clients whom I feel have a heavy biological loading for depression and actually need medications, and then there are other clients, like with her [an emotionally abused client Yvette had been describing], where it's, "Well, what are you living with day after day after day? And how are you going to feel when they live with that day after day and minute after minute?" It seems like the causes are much more interpersonal... (Yvette, 645-663)

Some other participants, including Yvette (663-666) felt that it was difficult to describe how they weighed out whether sociopolitical factors were relevant. Part of the picture may be added by examining therapist factors, such as exposure to feminist theory, that are hypothesized to be associated with incorporating a sociopolitical analysis in assessment and therapy with women. It is to these factors that I now turn.

*Therapist factors.* A variety of therapist factors which are associated with a sociopolitical approach in clinical work are discussed in this section. An examination of participants' interview protocols suggests that for some participants, a sociopolitical analysis of women's distress was simply more central to their way of understanding and working with women. The excerpts below reflect participants' impressions about personal factors that have shaped their own readiness to see gender as a salient variable, and/or shaped the style of sociopolitical approach taken with women. I also highlight patterns not necessarily noted by the respondents, but which also appeared to have an impact on how a sociopolitical analysis guided therapy.

*Theoretical orientation.* The therapist's theoretical orientation often shaped the degree of and manner in which sociopolitical factors were brought into therapy. Although therapy's overarching value of focusing on the individual was discussed at length earlier and will not be repeated here, it is worth noting that some therapists in the sample explicitly linked their tendency to focus on individual factors to their use of theoretical models which they defined as especially focused on individual problem-solving and intrapsychic forces. For example, Henry noted that his assumption of a very action-oriented, problem-focused style of working with clients led him to conceptualize, discuss, and resolve issues with clients at the individual or family level. This was the case even though he was aware that he perceived that some difficulties, such as patterns of marital conflict, were ultimately related to traditional gender-related power dynamics (415-537).

Xavier described a similar perspective. In addition, Diane and Jane linked their focus on the idiosyncratic and personal meanings of events, rather than a high degree of focus on social issues, to their training in psychodynamic models of distress and therapy.

In contrast, some clinicians argued that certain theoretical models of therapy were inherently better suited to appreciating issues of gender and power. For example, Margaret (168-220) and Steven (725-858) noted that some intergenerational and systems theory approaches are useful for helping therapists to consider larger systems in which clients' difficulties are embedded. Likewise, Theresa (481-487) noted that narrative therapy, with its emphasis on being aware of and questioning dominant social explanations, was also in line with helping women challenge traditional, and disempowering cultural narratives of women's distress. These participants claimed that their orientations primed or oriented them for attending to issues such as gender and power and were hence more conducive to the incorporation of a sociopolitical analysis in therapy.

Participants' theoretical orientation also shaped the specific type of sociopolitical techniques chosen for clinical work. For example, Ellen, who assumed a strongly CBT approach, described using cognitive restructuring and other CBT techniques to help clients examine disempowering and unrealistic gender-role expectations that they may have internalized:

> Well, in some ways it [feminist therapy] is very directly part of a cognitive approach. In other words, like the cognitive triad [model of depression]. What are your thoughts about yourself, the world, and your future? Where did you get these messages? With those questions, you literally make the unconscious conscious. You know, "I have been operating on the assumption that in order to be a successful woman, I have to be thin, be married, be working, have at least an MA..." you know, the current thing, and where do these assumptions come from? And when you make those assumptions conscious, they are literally sometimes written down, and that very process implies that you are considering or reconsidering sometimes and sometimes I think that what cognitive therapy does very specifically is ask two questions about the assumptions by which people live. And the first is, "Is this true?" And the second, and perhaps the more important one is, "Is this adaptive?" I mean, what are the consequences of adhering to this

> way of looking at things for me, and how do I feel about this? Does this make sense for me? So it's very much folded into the process that this is what you do in cognitive therapy is to seek an understanding of the worldview that a person has and then to say, "Well, there seems to be an issue here. (975-1015)

In contrast, Adam, a humanistic therapist, emphasized the corrective aspects for women of being in a therapeutic relationship that validated feelings and strivings not often reinforced by society (20-161). Similarly, Paula described herself as highly psychodynamically-oriented and noted that her style of therapy differed from supportive, humanistic styles of feminist therapy due to her assumption of a more expert, confrontative, interpretive role which could also involve some consciousness-raising. These examples and others suggest that the type of sociopolitically guided techniques used by therapists is partly shaped by the theoretical orientations in which they were trained.

*The therapists' brand of feminism influences a sociopolitical approach.* Many participants tied the tendency to utilize sociopolitically-informed techniques in therapy to the therapists' status as a feminist, someone with feminist values, or someone who is interested in gender issues (Steven, Felicia, Laura, Margaret, Paula, Theresa, Quinn, Wendy, Yvette, Jane). However, not all therapists who described incorporating a sociopolitical analysis or techniques also described themselves as feminists or as interested in gender and women's issues. In contrast, however, all those who described themselves in those terms reported incorporating a sociopolitical analysis in clinical work. For some participants, the particular definitions of feminism they emphasized seemed to be linked to the techniques they used. For example, Laura, who noted that she saw feminism as emphasizing "rejecting existing power arrangements and not making judgements for other people", tended to emphasize relationship techniques that empowered the individual and emphasized fitting theories to individuals, even if this meant

avoiding feminist interpretations that would not be meaningful to clients (1125-1145). Wendy noted that her understanding of feminism emphasized the idea that individuals should not be arbitrarily defined and limited by gender. This understanding was associated with her approach of encouraging clients to consider the widest range of behavioural options available to them, rather than feeling constrained by traditional gender arrangements (644-684). Another example of the way in which a therapist's definition of or version of feminism is associated with their use of a sociopolitical approach was illustrated by Ellen. Ellen noted that she defined feminism as very action oriented. This emphasis is reflected in her use of a skills-building, assertiveness training approach rather than more supportive approaches. Ellen made the link between her definition of feminism and her use of active, skills-building techniques explicit:

> Maybe this is the appeal of feminism to me. I'm not all that great about being really supportive and nurturant. I mean, I certainly am to a certain extent, but I'm more active than that. I'm not a hand-patter. I think some therapists can be hand-patters. To me, feminism is very active. One of the things I used to do when I was a doctoral student was to teach women assertiveness training. Which is one of the central threads of feminism. And I picketed and all that stuff when I was younger. So, I guess for me, that's the part. Feminism is very active. There are so many definitions of feminism... (1285-1302)

As described earlier, some types of feminism were perceived to be potentially harmful to clients on the basis that they risked failing to appreciate the individual's complexity and values. A number of clinicians in the sample contrasted their versions of feminism with more harmful, radical versions that they believed could influence therapy. Quinn, Margaret, Grace, and Laura contrasted their more moderate feminist views and related therapeutic interventions with the more extreme or rigid feminist views they had either come in contact with personally or professionally, or otherwise perceived to exist. Each of them described themselves as less radical and rigid than other therapists whose feminist approaches were considered to be unhelpful. Being less "radical"

meant many things, including being more flexible and less focused on applying sociopolitical analyses techniques, a greater willingness to acknowledge women's oppressive tendencies and men's oppression and need for services, and a greater willingness to act according to mainstream psychological practice (e.g., diagnosis) and to advocate seeking solutions within existing societal institutions. In contrast, more "radical" feminists were framed as more rigid and dogmatic in applying sociopolitical analyses and techniques, as advocating a departure from psychological practices that participants perceived as helpful, and as promoting services for women over the services for men. Below, Quinn described how her pro-woman approach was more positive and helpful to clients than therapy inspired by the more radical, anti-man variety:

> HG: You made the distinction that there are different levels of feminism that could potentially affect what you do with clients, and you made the distinction between being pro-woman and being anti-male. Could you tell me more about that?
>
> Quinn: I think to be...there is a strong component, although I don't think that it's the majority, but a vocal minority of feminists, who believe that men purposely and intentionally go out to subject women and to degrade them in order to keep them under control and powerless and so forth. There may be that strain of men, but I don't think that all men are like that (laughs). I think that they of course use their advantage, that they have available (laughs), but I don't think that I'm particularly willing to believe that all men subscribe to degrading women. I think it's a small minority of men. So I don't find the other view useful. The pro-woman approach I find much more useful because it gives me a wider range of structures that I can utilize to assist women with viewing society in a way that they can increase their power, make choices, sometimes in a way that can give them a greater advantage. Utilize what's available to them rather than remaining helpless and depressed. Oftentimes, I find that because women have no choice in terms of psychiatric services other than to take medication, I find that sometimes they are prescribed medication to keep them in a situation that they would be better off out of. And that I don't like. I think that's a situation that needs to be looked at. Women themselves often feel very helpless, very powerless, out of a relationship, even a relationship that's abusive and harmful to them. And they need assistance to help them recognize that what they're dealing with now is different than what they will have to deal with out of the situation. That taking pills to stay in a situation that is abusive and harmful to them may not be the best option for them, although they are going to have to go through a period of struggle and restabilize themselves out of that relationship. That's the kind of thing that I see as necessary. So I guess

> it's a more positive, more strength-oriented approach, but recognizing that what they're struggling against is social inequality, so it's not their fault, it's not what they're doing, but, this is what you can do to help. (755-820)

Margaret noted that other clinicians whom she perceived to be more radical have criticized her for practicing diagnosis, an activity she finds useful. She further described the difference between the influence of her feminism on her clinical work, contrasting it with the more extreme women-focused approach she has perceived in some feminist work. In the excerpt below, she describes a point of conflict that has occurred between herself and more radical feminist clinicians in the community:

> The difference is, that sometimes, even by accepting a male client, I think I might be perceived as taking away a space for a woman. And I don't push it that far. So, um...I think that's quite extreme. And while I'm able to say that I'm a feminist and I'm okay with that, I also say I'm a humanist, because I'm sensitive to the oppression of anyone. And I do recognize that women have been oppressed more historically, so that more time and energy...we need to be very careful about what services. But to me, that doesn't mean let's eradicate all the services for men. (479-509)

In a similar vein, Laura described feeling "attacked" by feminist therapists in a group supervision meeting for expressing her view that therapists should fit theories to individual clients (1125-1150). Grace described her brand of feminism as involving a "Vive le Difference" attitude to appreciating both genders, in contrast to what she perceived to be the views and actions of more "radical" feminist therapists. I include Grace's comment below:

> Grace: I guess if we had a continuum of a highly conservative approach to the world, I'd be a little bit towards the radical. And I'm thinking of myself as compared to some of the women who work at some of the sexual assault centres, and I don't want to stereotype, but some of the centres seem to be extremely radical in their beliefs about women's treatment. And if I were you, I'd talk to them. It would be interesting. But of course, they're not psychologists.
>
> HG: What do you see them doing that's different?

> Grace: Um, it sounds like that kind of analysis...political analysis is really at the forefront. And some...I don't want to stereotype, but some of these people in the paper are negative toward men. And my viewpoint is much more, "Vive le Difference", how can we figure out how to get along? Some of these people might have the approach that men can never be the victims, for example, that it's always the man's fault and that women could never be the aggressor, and physically hurt a male. And I don't think that's true, of course. That sort of thing is what I'm thinking of. But of course, these people aren't psychologists... (512-548)

In sum, participants' self-description as being feminist or having an interest in issues of gender appeared to be related to their use of a sociopolitical analysis and approach in clinical work. Therapists' versions of feminism also appeared to have some association with the degree of importance attached to a sociopolitical approach, and to the types of techniques that would and would not be used. In this sample, participants described themselves as less radical than other therapists they were aware of directly or had gathered impressions about indirectly. They contrasted their use of a more flexible and mainstream approach to therapy with that of the more rigid and women-focused techniques believed to be used by more radical feminists. It should be noted that I actively attempted to recruit more politically "radical" feminist therapists who might fit this description. While I did interview individuals who were nominated as "feminist" or "politically aware" by other participants, I did not encounter any clinicians who operated in "radical" manner described above.

*The therapist's reflections on personal experiences with sexism.* Four participants (Felicia, Theresa, Paula, and Jane) linked their emphasis or lack of emphasis on sociopolitical issues with women as related to their reflections on their own history of sexism. Felicia noted that her feminism and use of a sociopolitical approach in therapy are linked to her recognition of the difference between her own rights and those of her male sibling in childhood (1011-1018). A similar link was made by Theresa and by Paula, who described her own sense that her life and

most women's lives are to some degree constrained by fears of sexual assault, a perception she sometimes shares with clients (852-880). In contrast to these views, however, Jane reported that a sociopolitical analysis does not often seem salient to her work because sexism has generally not been a significant factor in her life:

> Jane: And so much of how we approach things as therapists is shaped by our own life.
>
> HG: Yes?
>
> Jane: And that has not been my experience. I do not think that I have been oppressed in my own life. You know, that really shapes our approach, for better or for worse. I know that there are people who are out there who are certainly much, I would say, feminist, than me, and they focus more on those issues. Whatever that means. And what I think, for example, compared to the people who work around here, we tend to focus on the individual, and their issues, although I cannot speak for everyone. (599-636)

In sum, participants' reflection on personal experiences of sexism was linked by them to the incorporation of a sociopolitical approach to therapy with women. In these cases, it is likely the therapists' reflections on sexist experiences that was important over and above the experiences themselves. It is possible, for example, that other participants may have had personal experiences with sexism that they did not discuss or see as relevant to the conceptualization and treatment of women's distress.

*The therapist's education in sociopolitical approaches to clinical work.* A number of clinicians in this sample stated that their use of a sociopolitical approach in therapy with women was influenced by the availability of training in women's issues and feminist therapy. Felicia, for example, noted that she took courses in counseling girls and women, had practica that involved working with a feminist orientation, and had feminist mentors as a beginning therapist (1019-1038). Margaret noted that many of the feminist therapists she knew received training at a local

university known for its feminist orientation. Many other participants who incorporated elements of a sociopolitical approach (e.g., Quinn, Laura, Paula, Wendy) complained that their graduate training did not encourage or teach them to consider gender or gender-based sociopolitical issues, and they were required to seek their own information. Others who did not incorporate a (strongly) sociopolitical approach (e.g., Grace, Xavier) also noted that their education did not address these issues.

*Theory: Guidance on how to do gender/socially-conscious therapy.* The availability of practical, concrete guides for conducting gender and socially-aware therapy was described as a factor influencing participants' incorporation of these models with female clients. A number of participants indicated that their ability to take gender into account in clinical work was hindered by a lack of practical information about how to carry this out. In contrast, others noted that available feminist research and media coverage of women's issues has been helpful in their clinical work.

*The need for more theory, validated theory, and concrete guidance.* A few participants argued that more guidance was required to assist clinicians incorporate a sociopolitical model of women's distress in clinical work. For example, Yvette noted:

> Yvette: One of the problems with trying to do feminist therapy that I've seen is that there isn't a lot of guidance in terms of actual techniques that you can use.
>
> HG: So it hasn't been well-operationalized.
>
> Yvette: Yeah. It's more like ideas about a framework of...the interpersonal within the larger context of therapy... (523-545)

Yvette went on to say:

> ...there's more generalized feminist therapy stuff which seems to, as I say, not have a lot of operational definitions to it. And the problem is, that the same sorts of problems are there in a lot of contemporary relational models if you're into

> psychodynamic approaches as I am. There isn't a lot about technique. It's all theory, and the same problem is there for feminist psychoanalytical stuff. It's all theoretical... (560-572)

In contrast to Yvette's concern that available guides may be too theoretical, other participants expressed a need for clearer, more empirically validated theory. Adam described his perception that utilizing a sociopolitical analysis is difficult because of the complexity of the concepts involved. Describing the need to take the social and political context of gender into account in clinical work, he noted:

> I personally think that we should try to. I personally try to take those things into account in what I do, but I don't think that psychology does take contextual and political things into account as much. And I don't think that we understand, because... I think that there are lots of different kinds of power, and how do you take all of that into account? (707-712)

In this way, the task of developing models of power and psychology and creating approaches to therapy that are related to those theories is seen to be complex and daunting.

Some of the participants also described difficulties in merging more traditional psychological theories with more contextualized ones. For example, Margaret felt that psychodynamic strategies which hold that clients may need to idealize the therapist at certain stages in therapy conflict with feminist values of de-emphasizing client-therapist power differences (567-642; 820-901). Felicia noted that she found merging a humanistic emphasis on following the individual and the more consciousness-raising element of feminist therapy to be difficult (906-918). Quinn noted that it is generally an ongoing struggle to find any psychological models that will be helpful to clients, because they often assume that clients possess greater power than many women practically have:

> It's interesting, because I keep looking for models that are going to be helpful. It's an ongoing search. A lot of the models are models that were developed on and for men rather than for women. A lot of times once you get into one of the models

> and try it out as we frequently do, it ends up being too simplistic and dependent upon power that women don't often have. And often times, its condescending or even degrading to women who are struggling the best that they can. So I pull them in, try them, and throw them out and try something else. There's an awful lot of psychology I think that's it become very obvious...it's built for men and not for women, so I try to be very sensitive to that. (276-324)

A lack of empirical support for feminist approaches was also described as a factor standing in the way of the incorporation of a sociopolitical approach to women's distress. Nadine noted that she tended not to incorporate sociopolitical techniques in her work with women because there has been little empirical work done to demonstrate that these interventions are useful (1225-1231). Instead, the organization for which she works adopted a more traditional cognitive-behavioural approach as a result of the availability of empirical data showing this approach as effective for the population it serves.

*Available theory on women, society, and distress has helped.* Other participants, such as Adam and Jane noted that they have used sociopolitical techniques such as consciousness-raising with clients when clients have presented with more stereotypical women's issues such as abuse or eating disorders which have been more extensively theorized by feminist writers and have received publicity in the media. Adam noted that he would be more ready to think about gender and power and engage in consciousness-raising when, for example:

> ...if it's an issue of abuse, or like, an eating issue, probably because those things have been in the media and they've been framed as women's issues, and we've probably all read at least some...feminist, I guess, literature on those issues. So they strike me in those terms more so than something less...theorized or publicized, I guess, would... (1167-1187)

In summary, some participants in the sample highlighted the fact that a lack of practical information on technique presented a problem. Others described experiencing difficulties as a result of the incompatibility of some aspects of feminist and more traditional theories, while one

participant touched on his perception of the theoretical complexities and difficulties of creating theories of power and intervention that can inform clinical work. In contrast, some participants expressed views that some orientations are more amenable to incorporating a sociopolitical analysis than are others. A few also described using media coverage of women's issues as a guide in their work.

*Broader social factors: Western individualism.* Three participants (Xavier, Adam, and Wendy) noted that broader social factors including Western individualism and patriarchy tended to render power differences and social issues impacting on individuals generally less visible and therefore less available for analysis by therapists. Xavier described, however, that psychology's individualistic focus is consistent with the larger culture focus on the individual. He also described his sense of the pros and cons of a focus on individual responsibility for clients:

> I think I still sort of apply...I don't know if they're North American standards or sort of...male standards. Because they kind of...I mean, the North American culture I think of is pretty independent, and "it's all yourself", and there's this overriding thing of individual responsibility. That's a big North American cultural norm. And, I find those things real useful in treatment; those people that accept those values tend to get on with things and try to improve their situations. Sometimes, though, not wisely, because sometimes those situations can't be perfect or under their control. And part of that is the cultural intolerance of imperfections. Some things simply have to be endured. And sometimes when people keep trying to find solutions, they are just going to make themselves miserable. So there's a fine line. But most of cognitive-behavioural therapy applied in rehab settings is pretty action-oriented. You go out and do things, you use them to go out and solve problems and improve your situation.... (4-24)

Xavier also noted:

> Psychology is probably too individualistic. Psychology is traditionally... When I was a graduate student, the standard text in psychology was called, "The Individual in Society". The individual came first, the rest came after. We probably are not as sensitive to things. It's like being a fish in water in a sense. It's all around you, and you can't even see it. And especially when you live in the world's dominant society, which is Western society, it's hard to see it. And individualism is one of the prime values in that society... (360-372)

Likewise, Adam described the individualistic focus in North American society as leading to a general inattention toward social factors impacting the individual (597-621). In general, these participants linked broader social factors with psychology's traditional individualistic focus.

### *Summary: Factors Associated with the Incorporation of a Sociopolitical Approach in Clinical Work*

A wide variety of setting, client, therapist, theoretical, and broader social factors are hypothesized to be related to therapists' incorporation of a variety of sociopolitically-based therapy values and techniques. Factors linked with the use of a sociopolitical approach, particularly consciousness-raising approaches, included a feminist or otherwise social-justice-oriented work climate, longer duration of treatment, and therapy in private settings as opposed to settings with specific but nonfeminist mandates. In addition, some participants indicated that they would be more likely to use sociopolitical techniques with disadvantaged or oppressed groups. Therapists who were feminist or otherwise interested in gender issues, who experienced gender and power issues to be salient in their own backgrounds, and who had training in women's issues appeared to be particularly likely to describe incorporating a sociopolitical approach to conceptualizing and treating women's distress.

Factors which appear to be associated with a lower degree of emphasis on gender and power issues included short-term treatment, work with clients who are low functioning and highly distressed, disorganized, or characterized as having defensive and self-defeating personality structures, and receipt of traditional psychotherapy training. In addition, the perceived lack of practical information on incorporating a sociopolitical approach, the theoretical complexity of

developing models of power and distress, as well as broader cultural values of individualism were also linked to difficulties in utilizing a sociopolitical approach with female clients.

# CHAPTER IV

# DISCUSSION

## Contextualizing the Framework

The goals of the present investigation were to broadly investigate the issue of clinicians' incorporation of a sociopolitical analysis in conceptualizing and treating women's distress, including the ways in which clinical work was transformed and broad contextual factors associated with various kinds of transformations. Overall, it was hoped that the investigation could have evocative power to inform and encourage debate about the best ways in which therapy can serve women. In the Discussion, I present a story consisting of a few main themes which capture the wide range of categories described above. In selecting main themes upon which to base my story, I drew on both what participants said directly as well as unspoken assumptions implied in what they took for granted. As this story is developed, the reader should bear in mind that the themes described reflect general patterns derived from stepping back from the details of the preceding section and developing a broader picture to tie the details together. As a result, some of the excerpts presented in the preceding chapter are better exemplars of these themes I will highlight in the Discussion than others.

Before I discuss the story in detail, an outline of the context of my work may allow readers to evaluate my interpretations of the data and to consider alternative interpretations which could add to the understanding of the topic at hand. Standards for evaluating qualitative research are numerous and reflect a number of philosophical standpoints. According to Elliot and colleagues (Elliot, Fischer, & Rennie,1999), however, the reader is able to judge the validity, reliability, and transferability of qualitative work when the researcher owns his or her perspective, provides

credibility checks for the framework that is developed, situates the sample, and contextualizes emerging themes with respect to the impact of the researcher's stimulus value and subjects' positionings within the research interaction.

First, a researcher's recognition and description of their values, interests, and assumptions can help readers consider alternative interpretations of the data. My commitment to feminism means that I am attentive to issues of power and feel that issues of gender, power, and sexism have been salient in my life. While this is the case, as a middle-class, white, heterosexual person, I am in many ways more privileged than others, and a researcher from a different social background might have noticed or highlighted more or different issues of power and oppression in interviews and analyses of the data. I would also frame my feminist values as more reflective of liberal or radical feminist traditions than a cultural feminist orientation. While I feel the sociopolitical interventions I identified above reflect liberal, radical and cultural perspectives, my own preferences within feminist theory led me to have concerns that I might potentially de-emphasize cultural feminist contributions from participants. In general, I do not believe that this was the case. Despite this, another researcher, perhaps one more interested in and committed to cultural feminist views might potentially have asked different questions of participants or emphasized results differently. My own preferences led me to ask participants explicitly about issues of power. It stands to reason that if I had perhaps asked about feminist therapy or sociopolitically informed therapy in some other, more open-ended way, I may have received different definitions and descriptions of sociopolitically-based practice which did not frame power centrally (e.g., see Marecek & Kravetz, 1998b). An open-ended approach may not have dramatically altered the results, however, because a number of participants, such as Quinn and Felicia, highlighted issues of power prior to my introduction of the concept.

As a graduate student in clinical psychology, I have an investment in the practice of therapy in general, and the practice of feminist therapy more specifically. This investment both served as the guiding force in developing the research to answer questions which were central to my desire to do good therapy that was also politically informed. Although I had concerns that my investment in therapy might lead to a less critical stance toward interviewees and the data than might be true of someone who was predominantly a researcher and not a clinician, I feel I was also willing to be skeptical about therapy, feminism, and the nature of the link between the two. Although I feel that therapy can be helpful, I also have concerns about its role in society, and alternatively, have also at times shared some of the concerns described by participants when attempting to integrate feminist values in clinical work. In particular, I wondered about issues of client agency and flexibility of conceptualization. As a feminist and clinician, I had insider status with regard to both camps, and an appreciation of and empathy for the vicissitudes of both positions, as well as a drive to reconcile the two approaches. It bears reasoning whether a researcher who was less invested in either clinical or feminist directions might have emphasized different frameworks in understanding and presenting the data.

In examining changes in my perspective over time, I found that when I first began to do interviews, I was fresh from reading feminist literature and had little experience in conducting feminist therapy. In fact, my questions about what feminist therapy looked like or should involve was a driving force behind the research. I think that I began interviews expecting to see a lot of black and white issues, in the sense of therapists who either would or wouldn't see feminism as useful, and I also tended to equate a sensitivity to issues of gender and power in therapy with consciousness-raising. My initial expectation that the field would be black and white led me to be surprised when I met feminist therapists who did not seem to do a lot of consciousness-raising,

therapists whom I thought would be politically conservative doing consciousness-raising, and a lot of more varied and subtle attempts at incorporating a sociopolitical analysis. In my first few interviews, therefore, I may have been more focused on following up on questions about consciousness-raising and relatively less sensitive about noticing and questioning more subtle incorporation techniques. My perception is that I quickly became aware of my need to monitor and increase my openness. I became more open-ended in my questioning, and feel that this enabled participants's concerns about what was most important to come through to a greater degree.

In discussing the issues of the credibility and transferability of the framework developed here, it should be noted that some researchers do not consider grounded theory to be a verificational methodology but rather one that emphasizes emergence and discovery (e.g., Glaser, 1978, p. 84, Glaser, 1992). This solely inductive view of grounded theory has been challenged by Rennie (1998a), however, who developed the concept of methodical hermeneutics as a logic of justification for the approach. According to Rennie, grounded theory does not require the added step of quantitative verification in order to establish meaningful frameworks for understanding phenomena. In contrast, the constant comparative method inherent in grounded theory methods is sufficient for that purpose. In addition to Rennie's convincing arguments for grounded theory's adequacy, my attempts, during interviews, to summarize and clarify participants' interviews statements, my continual rereading of whole interviews, and my use of multiple and varied informants as a form of triangulation likely enhanced the credibility and transferability of the themes derived above, as well as the more abstract discussion below. In addition, my presentation of extensive excerpts of interviews for the reader's perusal allows readers the opportunity to evaluate the credibility and transferability of the themes.

The transferability of the framework developed here may also be influenced by the interests of the sample of participants. My sample consisted of a greater percentage of feminist therapists than would likely be true of a randomly drawn sample of Ontario psychologists. As my findings are suggestive that those who identified as feminist therapists or interested in feminism, gender, or women's issues tended to describe a greater range of and emphasis on sociopolitical techniques than therapists who did not, my findings may overestimate the popularity of different sociopolitically-inspired models or techniques. At the same time, the sample also consisted of many clinicians who were nominated on the basis of their more conservative views or workplaces. It was also my perception that participants did not hesitate share their concerns about incorporating a gender analysis in therapy. The views of these individuals are represented in the framework, and in general, I do not feel that the sample is dramatically skewed in a pro-feminist direction. In contrast, I am tempted to say that the overall framework of relationships posited here is relatively generalizable. The perspectives that I found in conducting interviews with the present participants often fit with perspectives that I learned about informally as I proceeded through several years of clinical training and discussions I have had with other students and supervisors. I do not claim that the therapists who participated in my study are statistically representative of therapists in general. Nor do I argue that the perspectives identified here completely exemplify different categories of therapists (male therapists, female therapists, feminist therapists, etc.), but feel that this issue is a matter for future survey research.

Outlining my impressions of my own stimulus value and participants' positionings in relation to me can help readers further evaluate my work (Elliot et al., 1999). During interviews, I asked participants about their experiences of the interview generally, and in particular questioned whether they had felt compelled to talk a certain politically correct line. One participant indicated

that he saw me as 'powerful' and stated that although he did not feel intimidated, he felt some pressure to give coherent, thoughtful, intelligent (though not necessarily "politically correct") answers. Others indicated that they had not felt compelled to talk a line. I explicitly encouraged participants to describe views that were not politically correct, describing them as critical to the development of theories that would be of most help to women. It was my impression that participants did not hesitate to point out concerns about a feminist approach, and one even felt comfortable enough with me to discuss concerns that research focusing on gender might lead to the greater divisions between men and women. In general, I perceived the interviews to be pleasant, and the feedback I got from participants was that they felt similarly. I think that I came across as someone who was an insider and therefore sympathetic to feminists, but also to the vicissitudes of clinical psychologists' work. My personality, which I would describe as unassuming, interested in others' perspectives, and quiet rather than confrontive, may have helped others open up to me, and indeed, I was pleased to see that when interviews were transcribed, the segments of interviewees' speech were much more extensive than my own. On the other hand, my personality, my role as a student in relation to more seasoned clinicians may have made critical questioning somewhat more difficult for me than might have been true of other researchers. I do not feel, however, that this was a significant issue. In contrast, my status as a student may have led some participants to assume a "teacherly" role. At times, I felt as though some saw my interests as naive and were attempting to educate me about the vicissitudes of doing therapy in the "real world". This may have led them to be more complete and concrete than had might have been had they been speaking to a nonstudent, and so had advantages.

Grounded theory is also judged by its's ability to organize and integrate data in a way that offers parsimony while preserving nuances in the data. It is also judged by its plausibility and

resonance with readers. I will leave the evaluation of these issues up to readers, submitting that texts can generate a variety of meanings (Hare-Mustin & Marecek, 1988) and that my reading is only one of a number of possible interpretations, all of which can be deconstructed.

### *A Bigger Picture: Two Traditions in Conflict*

A review of the themes derived from client interviews highlights the importance of liberal humanistic philosophy in participants' use or non-use of a sociopolitical approach in therapy. The array of themes suggested that there was a tension present within and between participants, in their attempts to focus on female clients from a liberal, individualistic point of view, and also from a more critical feminist viewpoint which located clients within a society which disempowered them. It appeared that all participants, whether or not they identified as feminist therapists, feminists, or experts in gender or women's issues, found a sociopolitical model of women's distress to be useful, and sometimes used some techniques based upon this outlook in their work with female clients. It appears, therefore, that feminism has had a subterranean influence on the work of therapists from a variety of backgrounds. At the same time, however, only a subset of participants described the consideration of sociopolitical models of women's distress to be central to their therapeutic approach. In addition, though there was always a tension between a liberal humanist and critical feminist worldviews in participants' interviews, participants' descriptions of their practice and their concerns about the negative effects of feminist therapy suggested that liberal humanistic discourse often had the upper hand in shaping the subject and rules of therapy. This constrained the ways in which sociopolitical models and techniques were permitted to influence therapy for women.

In the discussion that follows, I will first outline the ways in which a feminist perspective was evident throughout the sample. Then, I will outline the ways in which a liberal humanist outlook appeared to constrain the incorporation of a sociopolitical analysis of women's distress in therapy. In outlining the tension between these two traditions, I do not intend to imply that either represent completely coherent, unified perspectives[3]. In addition, I do not intend to imply that liberal humanism and feminism oppose one another in all respects. Rather, the present contrasting of these two traditions represents a degree of ideal typification chosen in the interest of brevity and clarity. I also do not intend, in the discussion that follows, to imply that the perspectives and practices of the clinicians I interviewed were wrong in any absolute sense, or that therapeutic approaches must reduce all clients' distress to gender-related oppression or risk being regressive in nature. In contrast, I hope to point out some biases evident in the themes derived from interviews with an eye to informing debate about ways to improve psychological services for women. Liberal humanism is a centrally held value in Western culture, and while its identification and deconstruction does not necessarily require its rejection, this process can form a basis for making future choices about clinical practice. A liberal humanistic worldview likely has certain benefits and drawbacks for clients. This is also true of a critical feminist analysis of distress. I will outline these issues in the discussion that follows, and will present my own ideas about ways in which interventions may take advantage of the benefits of both models while avoiding their limitations.

### *An Undercurrent of Feminism in Participants' Work*

An examination of the themes derived from interviews suggests that an undercurrent of feminism influenced participants' clinical work. Virtually all participants in the study indicated

that explanatory models which highlighted women's subordinate social power were useful to them in understanding at least some forms of women's distress. This was particularly the case with forms of distress such as eating disorders and violence against women, which have been the focus of greatest feminist theorizing and media attention. In addition, many participants noted that they also incorporated some sociopolitically-based techniques in therapy. This was the case regardless of participants' identification as a feminist therapist, feminist, or expert on gender or women's issues, although the emphasis on a sociopolitical approach appeared to be more central for these individuals, and most central to a smaller subset of these participants. This subset's concerns about the personal and political ramifications of nonsocially-aware therapy, framing of therapy as inherently political, and relatively stronger emphasis on sociopolitically-informed techniques may be thought to reflect a deeper level integration of a critical feminist analysis of women's distress into clinical work.

While my sample may have consisted of individuals who were more interested in and able to talk about issues of gender and power than a randomly-drawn sample might have been, a range of conservative viewpoints were also tapped. In fact, a number of clinicians were nominated based on others' perceptions of their conservative beliefs. Among them were participants whom I had expected might not utilize sociopolitically-based explanations or consciousness-raising or other, similar techniques. A number of these participants, however, were able to give examples of having done just that. While one could argue that the low emphasis given by many participants to issues of gender and power represented a form of tokenism, these results may also suggest a level of feminist influence on therapy that has been heretofore undocumented. It may also suggest that the incorporation of a sociopolitical analysis is therapy is not a black and white picture. In contrast, there are many ways to incorporate a sociopolitical analysis in clinical work, and these

strategies are influenced by many factors. Clinicians working in a broad range of backgrounds use a sociopolitical frame depending on who the client is, the setting in which therapy takes place, the length of time available for treatment, the training of the therapist, the therapist's views of and concerns about feminism and feminist therapy, and other factors.

The few published studies examining the incorporation of feminist techniques in therapy have tended to focus only on the practices of identified feminist therapists or therapists adhering to a specific orientation, such as family therapy (e.g., Dankoski, Penn, Carlson, & Hecker, 1998; Hill & Ballou, 1998; Juntanen et al., 1994). Dankoski et al. (1988), for example, used a 17-item questionnaire of feminist family therapy techniques with a small sample of members of the American Association of Marital and Family Therapists (AAMFT) and found that individuals who did not identify as feminist therapists nonetheless reported using a relatively high level of feminist family therapy techniques. While the authors argued that the areas of marital and family therapy have been particularly fertile areas of feminist theorizing relative to other clinical approaches, the present study suggests that a sociopolitical model of women's distress also has a place in the work of a broader range of therapists who do not identify as feminist therapists, feminists, or experts on women's issues.

The reasons behind participants' incorporation of a sociopolitical model of women's distress may include the fact that many were seasoned clinicians who would have had some exposure to the women's movement over the course of the past thirty years. Indeed, some researchers (Beckwith, 1993; Kaplan, Winget, & Free,1990, Phillips & Gilroy, 1985) have hypothesized that clinicians' attitudes about gender roles have changed over the course of recent decades. Participants in this study also tied their consciousness to specific opportunities to train in the psychology of women, reflection on their own personal experience, and publicized accounts of

feminist theories obtained in the broad media. This suggests that increased theorizing and opportunities for training may be useful in the goal of encouraging a sensitivity to issues of gender and power amongst clinicians. Overall, while the adequacy of the level of sociopolitical and gender-concern shown by many participants may be questionable in relation to feminist critiques of therapy and overall feminist goals of consciousness-raising and social change, the present study suggests that clinicians with a wide variety of backgrounds find a sociopolitical model of women's distress to be useful.

*Liberal Humanism Constrains A Sociopolitical Approach*

Despite participants' endorsement of sociopolitical models of women's distress, a review of clinician's interviews suggests that liberal humanistic values often assumed primacy in shaping the subject and rules of therapy. In many ways, these values constrained the extent to which sociopolitical models were emphasized in clinical work. They also influenced the types of sociopolitically-based techniques that were considered appropriate or inappropriate. Overall, a liberal humanistic emphasis was evident in many participants' preference for an individualistic focus in therapy, fears that feminist therapy was political and therefore inappropriate for therapy, and concerns about promoting victimhood rather than agency and responsibility in clients. In general, participants tied these preferences and concerns to a de-emphasis of sociopolitical models of women's distress with clients, and a reluctance to use consciousness raising as opposed to less overtly political, relationship oriented techniques. The ways in which a liberal humanistic perspective constrained the incorporation of a sociopolitical analysis of women's distress in therapy is outlined further below.

*The focus on the individual.* The constraining effects of liberal humanistic discourse on a gender and power analysis in therapy was perhaps most evident in participants' framing of individual dynamics as the appropriate focus of therapy. Although all participants indicated that it was important to be aware of sociopolitical factors affecting their female clients' distress, in many cases their descriptions of therapy cases, preferred models of distress and treatment, and their concerns about emphasizing a sociopolitical model in clinical work suggested that they placed primary emphasis on helping clients analyze and resolve problems at individual and microsocial levels. This focus was evident in what participants said directly. For example, statements that the 'real' work of therapy pertained to idiosyncratic or common human intrapsychic dynamics, that clients already knew all they needed to know about the role of social factors in their distress, that a sociopolitical analysis of distress was a luxury rather than a priority, that clinicians should not categorize and limit individuals according to gender or other variables, and the tendency for many participants to bring up issues of gender and power indirectly, 'in passing', or if individual clients brought them up, all suggested an individualistic focus. Participants' liberal humanistic orientation was also suggested by what participants left unsaid. In other words, while a predominantly sociopolitical model was criticized, a mainstream intrapsychic focus was not problematized to the same degree, except by the subset of participants who demonstrated a deeper level of integration of critical feminist theory into their clinical work. As a result, although all participants noted that issues of gender and power impinged on clients, for many, if not most, these were seen as background factors to the central task of focusing on individual insight and self-actualization.

Participants' highlighting of individual insight and self-actualization as the primary goals of therapy has some important similarities with liberal humanistic values. As noted in the

introduction, liberal humanism has, at its heart, an essentialist and abstract conceptualization of the individual as the centre of the universe. This abstract, essential human self is not seen as gendered or historically grounded in any way. Instead, the personal realm is seen as distinct from the realm of politics (Frazer & Lacey, 1993). This universal, separate self is also seen as a bearer of rights and interests, and is believed to possess an innate drive to actualize its unique interests and goals. The protection of unique, individual strivings is elevated to a moral category in liberal society, and efforts to either view persons according to categories like race or gender, or to constrain individual rights for the higher social good are resisted on this basis (Eisenstein, 1981; Frazer & Lacey, 1993; Kitzinger, 1987, 1989). The separation of the personal from the political and the liberal reluctance to categorize persons, however, renders the connection between women's individual distress and broader issues of gender and social power less visible and less important than attending to the unique self and its goals. This lack of attention to the social context of distress, however, may ultimately serve to perpetuate a status quo which disempowers individuals on the basis of gender, race, class, or other social factors.

*Therapy, and the personal, are apolitical; feminism is political.* Another way in which participants' liberal construction of therapy constrained the incorporation of a sociopolitical model of women's distress in therapy pertained to concerns about imposing a political agenda in therapy. In particular, some participants linked their choice to refrain from consciousness-raising to concerns that consciousness-raising involved the imposition of a political agenda on clients. In arguing this position, many of these participants implied or directly described a view of therapy as value-free relative to a feminist approach. These concerns were in turn linked by some participants to their decision to de-emphasize or omit certain kinds of sociopolitically-informed techniques with female clients. Didactic consciousness-raising was viewed with particular

caution, and was avoided by some participants in favour of more exploratory, 'therapeutic', and less direct and political approaches to discussing gender and society.

The construction of psychotherapy as an intrapsychic and value-free enterprise may stem from many emphases inherent in a liberal humanist tradition. For example, liberalism's view of power as something negative which must be restrained in order to protect the individual rights of others may contribute to this perspective (Cobrin, 1995; Cushman, 1995; Frazer & Lacey, 1993). This image of power may lead clinicians to view their influence in here-and-now interactional terms and as something which they can and should withhold in order to respect the individuality of clients. This view, however, contrasts with other perspectives that hold the exercise of power to be an unavoidable component of all action or inherently involved in the perpetuation of power hierarchies within society. Foucault, for example, defined power as an inherent and unavoidable component of all action, and stressed the productive, rather than the prohibitive nature of power (see Cobrin, 1995; Fraser, 1989; Sullivan, 1984). Alternatively, Gramsci discussed power in terms of the propagation of social hegemonies via the reproduction and dissemination of dominant social practices, beliefs, and values through the media, family, schools, and other institutions (see Boggs, 1976, Prilleltensky, 1994; Sullivan, 1984).

When power is considered in these broader, regulatory ways, the impossibility of therapists' attempts to avoid imposing values or to eradicate the effects of their power on clients becomes clear (Cobrin, 1995). In fact, values may be seen to suffuse the entire process of therapy, beginning with decisions about who is in need of treatment, through the encouragement of clients' internalization of therapists' values, to decisions about when to end treatment (Cobrin, 1995). In this view, material emerging within the therapeutic hour is never something which is simply evoked from clients (Hare-Mustin & Marecek, 1988), and all therapies involve the creation of

moral discourses that have political repercussions (Cushman, 1995). The subversive nature of feminism, however, may lead it to be seen as particularly political. The often invisible nature of liberal humanism, and society's reluctance to identify it as an ideology rather than objective reality likely contributes to this state of affairs (Frazer & Lacey, 1993; Kitzinger, 1987). If, however, ideology is defined as "ideas serving as weapons for social interests" (Berger & Luckman, 1967, p.7, cited in Prilleltensky, 1994), it becomes apparent that both liberal humanistic and feminist views are ideological in nature. From this perspective, the decision to avoid considering and discussing gender or politics in therapy is not neutral but a value-laden act. In addition, psychology's failure to identify and examine liberal humanism as an ideology may ultimately support a status quo which privileges some segments of society and disempowers others. Ultimately, such a view suggests that therapists cannot avoid exercising power but can only attempt to direct it in ways that either support or subvert certain values (Cobrin, 1995).

*The importance of individual responsibility: creating angry victims.* A third way in which liberal humanist discourse constrained the incorporation of a sociopolitical approach to therapy with women pertained to participants' concerns that feminism categorized women as victims with little agency. For some participants, fears of passive victimhood were also linked to concerns about the promotion of a blaming, "anti-male" perspective that was unhealthy for women and society. Participants' concerns that a sociopolitical model of women's distress might offer a 'groupwise excuse' for problems, lead women to see their lives as 'fatal' and 'scripted', or promote blaming, 'anti-male' messages, appeared to reflect fears of victimhood. Some participants described these fears as a factor contributing to their de-emphasis of a sociopolitical model of women's distress in clinical work, or a relative preference for sociopolitical techniques that did not involve consciousness-raising. This was particularly the case when clients were

perceived to possess borderline personality characteristics which involved the externalization of blame.

A liberal humanistic outlook may have contributed to participants' concerns about the promotion of a victim role and their corresponding preference for highlighting personal responsibility. Liberal humanism's view of society as a collection of separate, equal individuals and its framing of self-actualization as a moral issue renders issues of social injustice less visible and credible than an emphasis on personal responsibility. In such a culture, victimhood is often seen as something that is shameful, and victims may be required to demonstrate powerlessness in order to be judged as worthy of recognition and help. Lamb (1999) and McCaffrey (199) have argued that dominant North American constructions of victimhood require demonstration of powerlessness and incapacitation. In describing the process by which victims in sexual assault cases are presented in court testimony, Lamb (1999) has outlined some of the ways in which evidence of plaintiff's agency are suppressed during the criminal justice process. Disempowering constructions of victimhood, therefore, may not be unique to feminist theories of the effects of patriarchy. Lamb and others (see Lamb, 1999) have argued for the development and promotion of enlarged, alternative constructions of victimhood which permit individuals to retain and demonstrate their agency.

Liberal humanistic psychology's negative view of victimhood is evident in its framing of politicization as indicative of psychological immaturity. Kitzinger (1987) has pointed out that many models of identity formation developed for use with oppressed groups such as lesbians, gays, and persons of colour tend to frame anger at societal discrimination as a necessary but penultimate step on the ladder to emotional maturity. In contrast, such models often frame ideal adjustment as the internalization of liberal humanistic values of a self-focus and integration into

wider society (Kitzinger, 1987). Similarly, therapeutic approaches which promote a political consciousness may be seen as encouraging clients' fixation at less than optimal stages of development. Despite the accumulation of literature which deconstructs these conformist assumptions, views of politicization as less mature than the relinquishing of anger may still have influenced participants' concerns about feminist therapies.

The accuracy of constructions of feminism as de-emphasizing agency in favour of a blaming attitude has been questioned, however. Some critics have argued against the existence of "victim feminism" (see Wolfe, 1994), arguing that original sources purported to be representative of such a tradition have been misrepresented. Atmore (1999) and Hammer (2002), for example, have argued that critics have misrepresented the views of Catherine McKinnon and other feminist theorists and incorrectly framed their arguments in black and white terms that emphasize victimhood. Feminist activists such as Dawn McCaffrey (199) have also studied the ways in which feminism facilitates an empowered "survivor" rather than passive victim role. In addition, many other feminist writers have discussed ways in which therapy can incorporate discussions of power and equality without stripping individuals of their agency and self-esteem. Lynn Parker (1998a,b,1999), for example, has outlined ways in which feminist family therapists can sensitively introduce gender and power in couples work in ways that protect and enhance clients' agency and self-esteem. Many interviews in the present study contained detailed examples of ways in which consciousness-raising can be done to respect clients' agency. Felicia, for example, talked about being "gentle", tentative, and respectful in socially conscious therapy. She also discussed her care not to make assumptions about the meaning of victimhood for clients. In addition, Laura suggested that her strategy of helping women on their own terms marked it as feminist and emancipatory. Further, some participants' concerns about feminist therapy's promotion of

victimhood were discussed with reference to the activities of front-line in women's shelters or rape crisis centres. To the extent that these front-line workers have a role which is different from that of a therapist, participants may have been reacting to perceptions of feminist therapy that were not accurate reflections of the way it has tended to be conducted by psychologists. This confusion is understandable in light of the fact that feminist approaches to therapy need to be described and evaluated more concretely. This is why the elaboration of ways in which therapists can incorporate an appreciation of gender and power was a goal of the current study.

Overall, the view of feminist therapy as promoting a victim orientation was associated with its de-emphasis by some participants. These participants preferred an approach which placed relatively greater emphasis on client agency and personal responsibility. While the identification and enhancement of client agency has merit (described in more detail below), a liberal humanistic emphasis on personal responsibility also risks blaming the victim for problems that are larger than themselves and perpetuating social injustice (Hammer, 2002). According to Sorisio (1997):

> Critiques of "victim feminism appeal to the myth of rugged individualism, the belief that anyone can overcome obstacles and succeed in North American society. Pouring historically exploited groups into one victimization mold enables some Americans to disclaim any debt we may have as citizens who greatly benefit from gender, class, and race inequity. It obscures the true dynamics of power and absolves responsibility. (pp. 140-141).

The reluctance of some participants to utilize sociopolitical models or techniques with clients who appear to be particularly damaged may be especially detrimental. While no one would likely argue that therapy with individuals who cannot eat, sleep, work, or who are dangers to themselves or others should first involve a focus on stabilization, an absolute rule about using a sociopolitical approach with distressed or 'borderline' individuals makes little sense. This is particularly the case because the most damaged individuals in our culture are also likely to be

those who have been most oppressed. They therefore have the most to lose from therapy which blames the victim, and the most to gain from a sociopolitical understanding of their distress.

### What Do Participants' Concerns Have to Offer Sociopolitically-Informed Therapy for Women?

As noted earlier, it should not be assumed from the foregoing analysis that a liberal humanistic approach in therapy with women has nothing of value to offer. Nor should the views and techniques related by participants assuming a deeper integration of a critical feminist perspective in therapy be accepted uncritically. The highlighting of values and assumptions which help to make sense of the lists of themes presented in the previous chapter can instead be understood as the beginning of a process through which the repercussions of different values can be evaluated.

Without losing sight of the risks of a liberal humanist focus for blaming individuals, participants also emphasized the perceived benefits to clients of therapies which focus on individuals. These benefits were framed as an important basis for participants' caution about incorporating a sociopolitical model of women's distress in clinical work, and their corresponding adherence to more individualistic approaches to assessment and therapy. These benefits included perceptions that clients felt respected, understood, and validated, and were more likely to continue the process of changing their lives for the better rather than foreclosing on this process when an individualized approach was used. One participant in this study (Laura) was particularly emphatic about her perception that it is an empowering and feminist act to help clients define their own needs and to help them on their own terms, an issue which some critical psychology literature may tend to overlook (Cobrin, 1995). The results of the present study, therefore, suggest important possibilities of focusing on the individual in therapy.

It would also be unfair and a missed opportunity to dismiss participants' concerns about some of the potentially negative effects of feminist therapies. Some of the views expressed by participants, including concerns about dogmatism, losing the individual, and promoting a victim-role, have also been identified within the feminist therapy literature as issues needing further examination and debate. Marecek (1999) for example, pointed to the tendency of some feminist therapists to frame their clients' difficulties in an overly simplistic, black and white manner that pitted innocent female victims against unrepentant, "almost evil" male perpetrators. She also argued that some feminist therapists' expansion of the concept of abuse runs the risk of rendering it meaningless for understanding women's distress. Overall, such simplistic understandings were described as unhelpful for feminist therapy's clients. These issues suggest that further debate is needed about the ways in which feminist therapy can address issues such as client agency and women's capacity for oppression and generally permit a more complex analysis which allows for the examination of a wide range of social and personal factors in women's distress.

## Addressing the Personal and the Political

Given the concerns raised above about the risks and benefits of both liberal humanist and feminist approaches to therapy, a therapeutic approach which would balance concerns for both the personal and political may help to capture the strengths and avoid the risks and limitations of each level of analysis. As one participant (Felicia) noted, therapists should not have to choose to focus on either personal or political issues, but clients may benefit from our commitment to conduct an analysis of both. In other words, what I am arguing for is a therapy which provides a true balance of focus on both individual and social concerns. This approach would contrast with the imbalanced reconciliation of individualist and feminist views that was most prominent in the

present sample. In acknowledging the inherently value-laden nature of their work, therapists should also be encouraged to consider the ethical, moral, and political repercussions of their approaches in therapy, and to give thought to the type of society they wish to promote through their efforts. This is in line with Prilleltensky's (1994) advocacy of Friere's (1971, 1975) process of conscientization as a guide to psychological research and practice.

Participants in this study provided some important suggestions about ways in which socially-conscious therapy can be practiced in a manner that attends to both individual psychological and microsocial concerns, and also issues of context. In fact, one goal of the study was to overcome the scarcity of even simple descriptive studies of therapies informed by a concern about women and power (Marecek & Kravetz, 1998a; see also see Women and Therapy, 1998, vol. 21). Although the incorporation of a sociopolitical approach is perhaps most often thought of in terms of consciousness-raising approaches, results suggest that clinicians transform therapy in accordance with an appreciation of gender and power in a range of ways. Some were framework-oriented approaches which address therapy format, process, or relationship-based issues, such as de-emphasis of power differentials in the therapy relationship and the honouring of the individual's goals, perspectives, and ways of making meaning. Other techniques were more overtly political and involved imparting content about women's power and its relationship to distress. Some reflected an adaptation of traditional approaches to resolve or counter internal, emotional conflicts and skills deficits related to gender role socialization. In sum, this study grounds certain techniques that have been described in feminist literature (discussing the sociopolitical context of distress, reducing power differences), and highlights some approaches that have not been discussed in the literature (e.g., use of gestalt techniques to resolve inner splits related to the negative aspects of gender role socialization). Other examples of incorporation that

have appeared in some feminist literature, such as demystifying the process of therapy did not emerge prominently in the present study. Overall, the study provides a more elaborated understanding of how concerns about gender and women's power can transform therapy. This will hopefully be useful to others who want to take such an approach but feel constrained by a lack of concrete examples to begin testing and thinking out this process for themselves.

While it is beyond the scope of the present study to comprehensively review and critique the wide range of techniques of incorporating a sociopolitical model of women's distress that were described by participants, many could be critiqued according to the goals of client politicization and social change. Format- or relationship-focused strategies such as validation, for example, could be criticized as insufficient, for example, when not accompanied by efforts to provide clients with an analysis of how issues of gender and power may partly relate to their personal distress (Marecek & Kravetz, 1998b). Theories stressing the validation of women's unique perspectives also runs into problems when the social construction of individuals' basic wants and desires is considered. In other words, individuals are not simply free to choose their subjectivity (Marecek & Kravetz, 1998b), and the assumption of an ahistorical, essential female self which should be honoured and validated may ultimately reinforce patriarchal notions of femininity (Marecek & Kravetz, 1998b; Westkott, 1990) rather than the creation of social change. In addition, one may wonder how the process of validating and honouring women's perspectives actually unfolds in situations where clients express views that are antifeminist in nature. In their critique of feminist discourse analysis, for example, Kitzinger and Wilkinson (1997) suggested that researchers were reluctant to do anything other than validate the perspectives of research participants. This highlights an issue that is relevant to feminist therapy. That is, do you honour clients' views even

when they go against feminist values? It appears that the issues involved are complex and could benefit from further investigation and debate.

Some feminist theorists and therapists have argued that the identification of sociopolitical approaches used by clinicians can guide efforts to define and standardize an overall theory of feminist therapy by consensus (Hill & Ballou,1998). The Division of Psychology of Women of the American Psychological Association (APA), for example, is debating petitioning the APA for Specialty Recognition for Feminist Psychological Practice (Remer, 1996). This process would entail codification of the principles and practices of feminist therapy, standards for training, and so forth. While there are some benefits for consensual development of a model of feminist therapy, the different approaches below imply different and sometimes contradictory stances toward the client. For example, therapists' attempts to de-emphasize power differences in therapy has been argued by some (Marecek & Kravetz, 1998b; some participants in this study) to stand in contrast with didactic consciousness raising, which implies more of an "expert" role. Others, such as Marecek and Kravetz (1998a) have argued that there is no single meaning of feminist therapy, but a multiplicity of ideas about principles, processes, and therapy goals. They question whether striving for uniformity and standardization is useful at this point, suggesting that the development of therapy that will be helpful to women may be better served by bringing the disparate ideas about the best ways of incorporating a sociopolitical approach into abrasive interaction. The present study's demonstration of a range of ways in which a sociopolitical model of women's distress can be incorporated into therapy, as well as ideas about who, when, where, and why to utilize particular approaches, can add to this debate.

In a broad sense, I would advocate that therapists be open about their values and guiding models with clients and utilize approaches which enable the examination of both personal and

political factors in client's distress. This would enable individuals to make personal choices with an understanding of the context of their personal distress. Sloan (1997) has suggested that Adorno's concept of negative dialectics could be used for guiding socially- and gender-conscious clinical work. Such an approach acknowledges the limitations inherent in both a predominantly personal or political focus, and enables a moving back and forth between these levels of analysis to provide a larger picture of individual distress in context. Alternatively, from a more psychodynamic perspective, Cushman's work (1995), highlights ways of conducting individual therapy that permits a shift away from discourse promoting an empty self separate from society. This narrative shift, in turn, allows for client and therapist to attend to both individual issues and a discussion of ways in which distress may be influenced by social world. Others have argued that narrative approaches to therapy form a particularly useful framework for conducting gender and politically-conscious therapy. These arguments tend to emphasize narrative therapy's attention to the relationship between power, knowledge, and discourse, and its' goal of helping clients to consider, unpack, and ultimately subvert dominant social narratives that disempower them (e.g., Hare-Mustin & Marecek, 1988; Hare-Mustin, 1998; Lee, 1997).

I put these examples forward as options for consideration in an ongoing search for ways in which therapy may attend to both the personal and political. Others may have different views about the best way in which therapy can help women. I also recognize that there is a dearth of information about the effectiveness of these approaches or of other feminist interventions generally. While Israeli and Santor's (2000) review of the efficacy of the feminist therapy suggests that the major components of feminist approaches are promising, more research is required to further examine the efficacy of sociopolitically-informed therapies for women.

Many critics interested in the women's movement and social justice more generally have argued that conducting therapy, even therapy which is socially- and gender-aware, is insufficient for a goal of helping clients. While it should not be concluded that therapy is futile until all of society has changed, it should be kept in mind that therapy is only one strategy in a larger struggle. Strategies by which clinicians can direct efforts at broader social change have been described by Caplan (1992 ) and Weiner (1998). Ultimately, a combination of individual and social change is required to create conditions which promote the well-being of women and society.

## Implications for the Education of Clinical Psychologists

The present study bears on issues relevant to the training of clinical psychologists. The present interviews suggested that clinical psychologists both identified and not identified as feminist therapists, feminists, or specialists in women's issues, found sociopolitical models of women's distress to be useful in their work. Some reported that coursework helped them bring a sociopolitical awareness into their work with female clients, while most did not have the opportunities to discuss issues of gender and power and their relationship to distress. Among clinicians, some found feminist theories of women's distress available in the broader media to offer valuable insights into clinical work with women. Others described negative views of feminism and feminist therapy. All of these findings suggest that educational opportunities which provide an opportunity to explore feminist models of psychopathology and treatment, and which examine different constructions of feminism may be useful in promoting a feminist approach in clinical work. Evidence of different attitudes about the relative extent to which either mainstream or feminist therapies were value-laden or political also suggests that training opportunities to

explore the values underlying therapy approaches may be useful. This type of educational experiences may help clinicians examine the political and moral repercussions of their work and to bring their therapeutic approaches in line with their own (and their clients') preferences for the kind of a society they are, in fact, helping to create (Prilleltensky, 1990a, 1994).

## Strengths and Contributions of the Research

The strengths of the present study derive from its exploratory nature and grounding in the concerns and practices of a wide range of clinicians providing front-line clinical services to women. The grounded nature of the results likely make the results and subsequent discussion particularly resonant and relevant for therapists who deal with women's distress on a day to day basis. It may be particularly evocative for those clinicians who are interested in incorporating a sociopolitical analysis of therapy in their work and are looking for techniques and overlying theories to problematize their current work and guide their future efforts. The present results ground and extend existing findings from the literature of feminist therapy and will hopefully contribute to the development of feminist therapy theory and practice. The description of concrete examples of ways in which consciousness-raising and other techniques are enacted are valuable given the lack of such information to guide therapists (Hill& Ballou, 1998). The results also extend the sparse existing literature pertaining to criticisms of taking a sociopolitical approach in clinical work (Krawitz & Watson, 1997; Lakin, 1991; Marecek, 1999; McLeod, 1994). A framework is offered to problematize liberal humanist concerns about mixing feminism and therapy, and to explore ways in which the dialectic of both the personal and political may be examined in therapy. The research also offers a demarcation of the range of conditions in which it may not be wise to utilize certain sociopolitically-based techniques. These kinds of ideas have

been underemphasized in the literature. Acknowledging these concerns should not preclude the use of these approaches, but can hopefully lead to further development of feminist therapy technique and theory and better treatment for therapy clients.

## Limitations of the Present Research and Recommendations for the Future

The trade-off for the opportunity to obtain a rich account of the inner logic of participants' work with women is uncertainty about the generalizability of the research. Future survey research could yield estimates of the frequency with which certain sociopolitical techniques or views were held by a wider sample of clinicians. The wide variety of themes derived from the current interview could be sampled to create more comprehensive surveys which tap not only techniques, but attitudes toward incorporating a sociopolitical analysis in clinical work.

The self-report nature of the data also represents a challenge to the external validity of the results. Participants could only describe practices, associated factors, clinical cases, and models of therapy to which they had conscious access (Rennie et al., 1988), and the link between participants' reports of their actual practices as perceived by other observers is unclear. Future research which involves interviewing clients or rating taped sessions of therapy may provide additional information about clinicians' incorporation of a sociopolitical analysis of women's distress in clinical work.

A few participants also indicated that they found the interview questions to be broad, and stated that they would have appreciated the opportunity to have had the questions in advance so that they could consider the issues raised more carefully. While the single interview format of the study may have led clinicians to emphasize their most pressing concerns and may therefore have

resulted in focused and relevant themes, more detailed, nuanced information may have been obtained by providing questions in advance, or conducting repeat interviews.

In addition to the ideas outlined above, future grounded theory studies could contribute to the development of feminist therapy theory by focusing in greater detail on some of the specific themes identified in this broader study. The present study is an overview of major ways in which a sociopolitical analysis of women's distress can shape therapy, as well as the main factors which influence the utilization of these approaches. Future studies could address a particular kind of sociopolitical technique, concern about feminist therapy, or workplace or therapist factor influencing clinicians' use of a sociopolitical model of women's distress. The issue of validating and honouring clients perspectives noted earlier, for example, is likely a complex issue which could be examined in more detail. As Glaser (1978) has noted, the strength of grounded theory lies in its ability to adapt in light of new and additional information. Further grounded theory studies which address any aspect of the framework described above could lead to a more complex and sophisticated account of the vicissitudes of incorporating an appreciation of gender and power in clinical work with women.

## ENDNOTES

1. This analysis involved the review and coding of several hundred pages of verbatim text, and an iterative process by which several hundred codes were compared and reduced to the overarching themes described in the Results section.

2. When asked about their own practices, some participants discussed their views and practices by contrasting or contextualizing them with the perceived views and practices of peers.

3. For a discussion of the different traditions within feminism, feminist therapies, and liberal philosophy, see Jaggar, 1983, Enns, 1997, and Frazer & Lacey, 1993, respectively.

# REFERENCES

Albee, G. W. (1982). The politics of nature and nurture. *American Journal of Community Psychology, 10,* 4-36.

Albee, G. W. (1986). Toward a just society: Lessons from observations on the primary prevention of psychopathology. *American Psychologist, 41,* 891-898.

American Psychological Association (1978). Guidelines for therapy with women: Task force on sex bias and sex roles stereotyping in psychotherapeutic practice. *American Psychologist, 34,* 1122-1123.

Aneshensel, C. S., Frerichs, R. R., & Clark, V. A. (1981). Family roles and sex differences in depression. *Journal of Health and Social Behaviour, 22,* 379-393.

Atmore, C. (1999). Victims, backlash, and radical feminist theory (or, the morning after they stole feminism's fire). In S. Lamb, Ed., *New versions of victims: Feminists struggle with the concept* (183-213). New York: New York University Press.

Baber, K. M., & Allen, K. R. (1992). *Women and families: Feminist reconstructions.* New York: Guilford.

Basow, S.A. (1986). *Gender stereotypes: Traditions and alternatives (2nd ed.).* Monterey, CA: Brooks/Cole.

Beardsley, B., & Morrow, S. (1998, March). *The development of a feminist therapy scale.* Presented at the Annual Convention of the Association of Women in Psychology, Baltimore, MD.

Beckwith, J. B. (1993). Gender stereotypes and mental health revisited. *Social Behavior and Personality, 21,* 85-88.

Beit-Hallahmi, B. (1974). Salvation and its vicissitudes: Clinical psychology and political values. *American Psychologist, 29*, 124-129.

Berger, P. L., & Luckman, T. (1966). *The social construction of reality: A treatise in the sociology of knowledge*. New York: Doubleday.

Bernard, J. (1972). *The future of marriage*. New York: Bantam.

Betz, N. E., & Fitzgerald, L. E. (1987). *The career psychology of women*. New York: Academic Press.

Blair, S. L., & Lichter, D. T. (1991). Measuring the division of household labor: Gender segregation of housework among American couples. *Journal of Family Issues, 12*, 91-113.

Blood, R.O., & Wolfe, D. M. (1960). *Husbands and wives: The dynamics of married living*. New York: Free Press.

Broverman, I. K., Broverman, D. M., Clarkson, F. E., Rosencrantz, P. S., & Vogel, S. R. (1972). Sex role stereotypes and clinical judgments of mental health. In J. M. Bardwick (Ed.), *Readings on the psychology of women*. New York: Harper & Row.

Brown, L. S. (1994). *Subversive dialogues: theory in feminist therapy*. New York: BasicBooks.

Brown, L. S. (1990b). Taking account of gender in the clinical assessment interview. *Professional Psychology: Research and Practice, 21*, 12-17.

Brown, L. S. (1990c). What's addiction got to do with it? A feminist critique of codependency. *Psychology of Women Newsletter, 17*, 3-4.

Brown, L. S. (1992b). While waiting for the revolution: The case for a lesbian feminist psychotherapy. *Feminism & Psychology, 2*, 239-253.

Brown, L. S. (1994). *Subversive dialogues: Theory in feminist therapy.* New York: Basic Books.

Browne, A. (1993). Violence against women by male partners: Prevalence, outcomes, and policy implications. *American Psychologist, 48*, 1077-1087.

Cammaert, L. P., & Larsen, C. C. (1988). Feminist frameworks of psychotherapy. In M. Dutton-Douglas and L. E. A. Walker (Eds.), *Feminist Psychotherapies: Integration of Therapeutic and Feminist Systems*. Norwood, NJ: Ablex.

Canada Health Monitor. (1992). *Highlights reports survey #6.* Toronto: Price Waterhouse and Earl Berger.

Canadian Panel on Violence Against Women. (1993). *Changing the landscape: Ending violence achieving equality: Final report of the Canadian Panel on Violence Against Women.* Ottawa: Author.

Caplan, P. J. (1992). Driving us crazy: How oppression damages women's mental health and what we can do about it. *Women & Therapy, 12*, 5-28.

Caplan, P. J. (1984). The myth of women's masochism. *American Psychologist, 39*, 130-139.

Carmen, E. H., Rieker, P. P., & Mills, T. (1984). Victims of violence and psychiatric disorders. *American Journal of Psychiatry, 141*, 378-383.

Chaney, S. E., & Piercy, F. P. (1988). A feminist family therapy behavior checklist. *American Journal of Family Therapy, 16*, 305-318.

Charmaz, C. (1983). The grounded theory method: An explication and interpretation. In R. M. Emerson (Ed.), *Contemporary field research: a collection of readings* (pp.109-126). Boston: Little, Brown and Co.

Charmaz, C. (1995). Grounded theory. In J. A. Smith, R. Harre, & L. Van Langenhove (Eds.), *Rethinking methods in psychology*. (pp. 27-49). Thousand Oaks, CA: Sage

Chodorow, N. J. (1978). *The reproduction of mothering*. Berkeley, CA: University of California Press.

Cobrin, P. (1995). *Psychotherapy's impact on society*. Unpublished doctoral dissertation, Department of Psychology, University of Windsor, Windsor, Ontario, Canada.

Crawford, M., & Marecek, J. (1992). Psychology reconstructs the female 1968-1988. In J. Bohan (Ed.), *Seldom seen, rarely heard: Women's place in psychology*. Boulder, CO: Westview.

Creswell, J. W. (1994). *Research design: Qualitative and quantitative approaches*. Thousand Oaks, CA: Sage.

Crosby, F. J. (1982). *Relative deprivation and working women*. Oxford: Oxford University Press.

Cushman, P. (1995). *Constructing the self, constructing America: a cultural history of psychotherapy*. New York: Addison-Wesley.

Dankoski, M.E., Penn, C. D., Carlson, T. D., & Hecker, L. L. (1998). What's in a name? A study of family therapists' use and acceptance of the feminist perspective. *The American Journal of Family Therapy, 26*, 95-104.

Elliott, R., Fischer, C., & Rennie, D. L. (1999). Evolving guidelines for publications of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38*, 215-229.

Fitzgerald, L. F. (1993). Sexual harassment: Violence against women in the workplace. *American Psychologist, 48,* 1070-1076.

Fitzgerald, L. F., & Nutt, R. (1986). The Division 17 principles concerning the counseling/psychotherapy of women: Rationale and implementation. *The Counseling Psychologist, 14,* 180-216.

Frazer, E., & Lacey, N. (1993). *The politics of community: A feminist critique of the liberal-communitarian debate.* Toronto: University of Toronto Press.

Friedan, B. (1963). *The feminine mystique.* New York: Norton.

Friere, P. (1971). *Pedagogy of the oppressed.* New York: Seabury.

Friere, P. (1975). *Cultural action for freedom.* Harvard Educational Review Monograph, 1.

Freud, S. (1901/1976). *The psychopathology of everyday life.* (Transl. J. Strachey). London: Penguin.

Freud, S. (1925/1964). Some psychical consequences of the anatomical distinctions between the sexes. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud (Vol. 19, p..248-258).* London: Hogarth.

Gayford, J. J. (1975). Wife battering: A preliminary survey of 100 cases. *British Medical Journal, 1,* 194-197.

Gilgun, J. f. (1994). Hand into glove: The grounded theory approach and social work practice research. In E. Sherman & W. J. Reid (Eds.), *Qualitative Research in Social Work.* (pp.152-160). New York: Columbia University Press.

Gilman, C. P. (1973). *The yellow wallpaper.* New York: The Feminist Press.

Glaser, B. J., (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory.* Mill Valley, CA: Sociology Press.

Glaser, B. J. (1992). Emergence vs. forcing: The basics of grounded theory analysis. Mill Valley, CA: Sociology Press.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research.* Chicago: Aldine.

Goldberg, G. S. (1990). Canada: Bordering on the Feminization of Poverty. In G. S. Goldberg & E. Kremen (Eds.), *The feminization of poverty: Only in america?* (pp.59-90). New York: Praeger

Goldberg, G. S., & E. Kremen (Eds.). (1990). *The feminization of poverty: Only in america?*. New York: Praeger.

Goldenberg, N. (1976). A feminist critique of Jung. *Signs: Journal of Women in Culture and Society, 2.*

Goldner, V. (1985). Feminism and family therapy. *Family Process, 24*, 31-47.

Goldner, V. (1991). Feminism and systemic practice: Two critical traditions in transition. *Journal of Family Therapy, 13*, 95-104.

Gove, W. (1972). The relationship between sex roles, marital status, and mental illness. *Social Forces, 51*, 34-44.

Gove, W., & Geerken, M. R. (1976). Response bias in survey of mental health: An empirical investigation. *American Journal of Sociology, 82*, 1289-1317.

Gove, W., & Tudor, J. F. (1973). Adult sex roles and mental illness. *American Journal of Sociology, 78*, 812-835.

Graham, N. Z. (1993). Women in the workplace. *Canadian Social Trends, 28*, 6.

Gray, N., Alterman, T., & Litman, E. (1988). Women's issues in psychotherapy: Training issues for mental health professionals. *Women & Therapy, 7*, 101-111.

Greenspan, M. (1993). *A new approach to women and therapy.* Blue Ridge Summit, PA: TAB Books.

Gruber, J. E., & Bjorn, L. (1982). Blue-collar blues: The sexual harassment of women autoworkers. *Work and Occupations, 9,* 271-298.

Guba, E., & Lincoln, Y. (1989). *Fourth generation evaluation.* Newbury Park, CA: Sage.

Gutek, B. A. (1989). Relocation, family, and the bottom line: Results from the Division 35 survey. *Psychology of Women Quarterly, 16,* 5-7.

U.S. Federal Bureau of Investigation. (1986). *Crime in the United States: Uniform crime report.* Washington, DC: Department of Justice.

Hammer, R. (2002). *Antifeminism and family terrorism: a critical feminist perspective.* Lanham, MD: Rowman & Littlefield.

Hanisch, C. (1971). The personal is political. In J. Agel (Ed.), *The radical therapist* (pp. 152-157). New York: Ballantine.

Hare-Mustin, R. T. (1978). A feminist approach to family therapy. *Family Process, 17,* 181-194.

Hare-Mustin, R. T. (1998). Challenging traditional discourses in psychotherapy: Creating space for alternatives. *Journal of Feminist Family Therapy, 10,* 39-56.

Hare-Mustin, R. T., & Marecek, J. (1990a). On making a difference. In R. T. Hare-Mustin & J. Marecek (Eds.), *On making a difference: Psychology and the construction of gender* (pp. 1-21). New York: Yale University Press.

Hare-Mustin, R. T., & Marecek, J. (1990b). Beyond difference. In R. T. Hare-Mustin & J. Marecek (Eds.), *On making a difference: Psychology and the construction of gender* (pp. 184-200). New York: Yale University Press.

Hare-Mustin, R. T., & Marecek, J. (1988). The meaning of difference: Gender theory, postmodernism, and psychology. *American Psychologist, 43*, 455-464.

Hare-Mustin, R. T., & Marecek, J. (1989). Thinking about postmodernism and gender theory. *American Psychologist, 44*, 1333-1334.

Hill, M., & Ballou, M. (1998). Making therapy feminist: A practice survey. *Women & Therapy, 21*, 1-16.

Hoschild, A. R. (1989). *The second shift: Working parents and the revolution at home*. New York: Viking.

Hossain, Z., & Roopmarine, J. L. (1993). Division of household labor and child care in dual-earner African American families with infants. *Sex Roles, 29*, 571-584.

Israeli, A. L., & Santor, D. A. (2000). Reviewing effective components of feminist therapy. *Counselling Psychology Quarterly, 13*, 233-247.

Jack, D. (1991). *Silencing the self: Women and depression*. Cambridge, MA: Harvard University Press.

Jacobsen, A., & Richardson, B. (1987). Assault experiences of 100 psychiatric inpatients: The need for routine inquiry. *American Journal of Psychiatry, 144*, 908-913.

Jaggar, A. M. (1983). *Feminist politics and human nature*. Sussex: The Harvester Press.

Johnson, P. (1976). Women & power: Toward a theory of effectiveness. *Journal of Social Issues, 32*, 99-110.

Juntunen, C. L., Atkinson, D. R., Reyes, C., & Gutierrez, M. (1994). Feminist identity and feminist therapy behaviors of women psychotherapists. *Psychotherapy, 31*, 327-333.

Kantrowitz, R. E., & Ballou, M. (1993). A feminist critique of cognitive-behavioural therapy. In L. S. Brown & M. Ballou (Eds.), *Personality and psychopathology: Feminist reappraisals*. New York: Guilford.

Kaplan, M. J., Winget, C., & Free, N. (1990). Psychiatrists' beliefs about gender-appropriate behavior. *American Journal of Psychiatry, 147*, 910-912.

Kilpatrick, D., Resick, P., & Veronen, L. (1981). Effects of a rape experience: A longitudinal study. *Journal of Social Issues, 37*, 105-122.

Kilpatrick, D., Veronen, L., & Resick, P. (1979). The aftermath of rape: Recent empirical findings. *American Journal of Orthopsychiatry, 49*, 658-669.

Kim, E. H. (1986). On silk wings: Asian American women at work. In J. B. Cole (Ed.), *All American women: Lines that divide, ties that bind.* (pp. 95-100). New York: MacMillan.

Kim, U. (1995). Psychology, science, and culture: Cross-cultural analysis of national psychologies. *International Journal of Psychology, 30*, 663-679.

Kitzinger, C. (1992). The 'real' lesbian feminist therapist: who is she? *Feminism & Psychology, 2*, 262-264.

Kitzinger, C. (1991). Feminism, psychology, and the paradox of power. *Feminism & Psychology, 1*, 111-129.

Kitzinger, C. (1991). Politicizing psychology. *Feminism and Psychology, 1*, 49-54

Kitzinger, C. (1990). "Resisting the discipline". In E. Burman (Ed.), *Feminists in psychological practice*. London: Sage.

Kitzinger, C. (1989). Individualism and the feminist challenge. *Contemporary social psychology*, 38-46.

Kitzinger, C. (1987). *The social construction of lesbianism*. London: Sage.

Kitzinger, C., & Perkins, R. (1993). *Changing our minds*. New York: New York University Press.

Kitzinger, C., & Wilkinson, S. (1997). Validating women's experience? Dilemmas in feminist research. *Feminism & Psychology, 7*, 566-574.

Klonoff, E. A., Landrine, H., & Campbell, R. (2000). Sexist discrimination may account for well-known gender differences in psychiatric symptoms. *Psychology of Women Quarterly, 24*, 93-99.

Koss, M. P. (1988). The hidden rape victim: Personality, attitudinal, and situational characteristics. *Psychology of Women Quarterly, 9*, 193-212.

Koss, M. P., & Burkhart, B. R. (1989). A conceptual analysis of rape victimization. *Psychology of Women Quarterly, 13*, 27-40.

Krawitz, R., & Watson, C. (1997). Gender, race, and poverty: Bringing the sociopolitical into psychotherapy. *Australian and New Zealand Journal of Psychiatry, 31*, 474-479.

Laframboise, D. (Nov. 14, 1998). Battered shelters: Criminal charges, mismanagement, infighting, and sexual politics have left many women's shelters as bruised as the people they serve. *National Post* (pp.B1/Front) Toronto.

Lakin, M. (1991). Some ethical issues in feminist therapeutic groups for women. *International Journal of Group Psychotherapy, 41*, 199-215.

Lamb, S. (1999). Constructing the victim: Popular images and lasting labels. In S. Lamb (Ed.), *New versions of victims: feminists struggle with the concept*. (108-138). New York: New York University Press.

Lamb, S., (Ed.) (1999). *New versions of victims: feminists struggle with the concept*. New York: New York University Press.

Landrine, H., & Klonoff, E. A. (1997) *Discrimination against women: Prevalences, consequences, and remedies*. London: Sage.

Landrine, H., Klonoff, E. A., Gibbs, J., Manning, V., et al. (1995). Physical and psychiatric correlates of gender discrimination: an application of the schedule of sexist events. *Psychology of Women Quarterly, 19.*

Lee, J. (1997). Women re-authoring their lives through feminist narrative therapy. *Women & Therapy, 20*, 1- 22.

Lerman, H. (1992). The limits of phenomenology: A feminist critique of the humanistic personality theories. In L. S. Brown & M. Ballou (Eds.), *Personality and psychopathology: Feminist reappraisals* (pp.8-19). New York: Guilford.

Lerman, H. (1986). *A mote in Freud's eye*. New York: Springer.

Lerner, H. G. (1988). *Women in therapy*. Northville, NJ: Jason Aronson.

Lerner, H. G. (1986). *The creation of patriarchy*. New York: Oxford University Press.

Lerner, H. G. (1987) Is family systems theory really systemic? A feminist communication. In L. Braverman (Ed.), *Women, feminism, and family therapy*. New York: Haworth.

Lerner, M. (1991). *Surplus powerlessness: The psychodynamics of everyday life...and the psychology of individual and social transformation*. London: Humanities Press International.

Lorber, J. (1993). *Paradoxes of gender*. New Haven: Yale University Press.

Luepnitz, D. A. (1988). *The family interpreted: Feminist theory in clinical practice*. New York: Basic Books.

Luxton, M. (1990). Changing patterns in the gendered division of labour in the home. In M. Luxton, H. Rosenberg, & S. Arat-Koc (Eds.), *Through the kitchen window: The politics of the home and family*. Toronto: Garamond.

MacLeod, E. (1994). *Women's experience of feminist therapy and counseling.* Buckingham, PA: Open University Press.

Malloy, K., Smith, K., & McCloskey, K. (1998, August). *Graduate training in the theory and practice of feminist therapy.* Round table discussion and paper presented at the Annual Convention of the American Psychological Association. San Francisco, CA.

Marecek, J. (1999). Trauma talk in feminist clinical practice. In S. Lamb (Ed.), *New perspectives on victims: Feminist struggle with the concept.* (pp. 158-182) New York: New York University Press.

Marecek, J., & Hare-Mustin, R. T. (1991). A short history of the future: Feminism and clinical psychology. *Psychology of Women Quarterly, 15,* 521-536.

Marecek, J., & Kravetz, D. (1998a). Putting politics into practice: Feminist therapy as feminist praxis. *Women & Therapy, 21,* 17-36.

Marecek, J., & Kravetz, D. (1998b). Power and agency in feminist therapy. In Seu, I. B., & Heenan, M. C. (Eds.), *Feminism and psychotherapy: Reflections on contemporary practice.* (pp. 13-29) Thousand Oaks, CA: Sage.

Maypole, D. E. (1986). Sexual harassment of social workers at work: Injustice within? *Social Work, 28,* 385-390.

McCaffrey, D. (1998). Victim feminism/victim activism. Sociological Spectrum, 18, 263-284.

Mednick, M. (1989). On the politics of psychological constructs: Stop the bandwagon, I want to get off. *American Psychologist, 44,* 1118-1123.

Miller, J. B. (1986). *Toward a new psychology of women (2nd Edition).* Boston, MA: Beacon Press.

Milton, M., & Legg, C. (2000). Politics in psychotherapy: therapists' responses to political material. *Counselling Psychology Quarterly, 13*, 279-291.

Mirowsky, J., & Ross, C. E. (1989). *Social causes of psychological distress*. Hawthorne, NY: Aldine de Gruyter.

Morrow, S. L., & Hawxhurst, D. M. (1998). Feminist therapy: Integrating political analysis in counseling and psychotherapy. *Women & Therapy, 21*, 37-50.

Mowbray, C. T. (1995). Nonsexist therapy: Is It? *Women & Therapy, 16*, 9-30.

Nolen-Hoeksema, S. (1990). *Sex differences in depression*. Stanford, CA: Stanford University Press.

Nieva, V. F., & Gutek, B. A. (1981). *Women and work: A psychological perspective*. New York: Praeger.

Okun, B. F. (1992). Object relations and self-psychology: Overview and feminist perspective. In L. S. Brown & M. Ballou (Eds.), *Personality and psychopathology: Feminist reappraisals* (pp. 20-45). New York: Guilford.

Page, S. On gender roles and perceptions of maladjustment. *Canadian Psychology, 28*, 53-59.

Parker, L. (1997a). Unraveling power issues in couples therapy. *Journal of Feminist Family Therapy, 9(2)*, 3-20.

Parker, L. (1997b). Keeping power issues on the table in couples work. *Journal of Feminist Family Therapy, 9(3)*, 1-25.

Parker, L. (1998). The unequal bargain: Power issues in couples therapy. *Journal of Feminist Family Therapy, 10*, 17-37.

Pearlin, L. I. (1975). Status inequality and stress in marriage. *American Sociological Review, 40*, 344-357.

Peplau, L. A. (1984). Power in dating relationships. In H.H. Kelly et al. (Eds.), *Women: A feminist perspective (3rd ed)*, pp. 106-121). Palo Alto, CA: Mayfield.

Peplau, L. A., & Gordon, S. L. (1985). Women and men in love: Gender differences in close heterosexual relationships. In V. E. O'Leary, R. K. Unger, & B.S. Wallston (Eds.), *Women, gender, and social psychology* (pp.257-291). Hillsdale, NJ: Erlbaum.

Perkins, R. E. (1992). Waiting for the revolution or working for it? A reply to Laura Brown and Katherine Sender. *Feminism & Psychology, 2*, 258-261.

Perkins, R. E. (1991). Therapy for lesbians? The case against. *Feminism & Psychology 1*. 325-338.

Phillips, R. D., & Gilroy, F. D. (1985). Sex-role stereotypes and clinical judgements of mental health: the Broverman's findings reexamined. *Sex Roles, 12*, 179-193.

Polster, M. (1978). Women in therapy: a gestalt therapist's view. In V. Franks and V. Burtle (Eds.), *Women in therapy* (pp. 247-262). New York: Brunner/Mazel.

Prozan, C. (1993). The fears of women. In C. Prozan, *The technique of feminist psychoanalytic therapy* (pp.65-111). Northvale, NJ: Jason Aronson.

Pravder-Mirkin, M. (1990). *The social and political contexts of family therapy*. Toronto: Allyn and Bacon.

Prilleltensky, I. (1989). Psychology and the status quo. *American Psychologist, 44*, 795-802.

Prilleltensky, I. (1990a). Enhancing the social ethics of psychology at the service of social change. *Canadian Psychology, 31*, 310-319.

Prilleltensky, I. (1990b). The politics of abnormal psychology: Past, present, and future. *Political Psychology, 11*, 767-785.

Prilleltensky, I. (1990c). On the social and political implications of cognitive psychology. *The Journal of Mind and Behaviour, 11*, 127-136.

Prilleltensky, I. (1992). Humanistic psychology, human welfare and the social order. *The Journal of Mind and Behavior, 13*, 315-328.

Prilleltensky, I. (1994). *The morals and politics of psychology: Psychological discourse and the status quo*. Albany, New York: State University of New York Press.

Radloff, L. S. (1975). Sex differences in depression: The effects of occupation and marital status. *Sex Roles, 1*, 249-267.

Rennie, D. L. (2000). Grounded theory methodology as methodical hermeneutics: reconciling realism and relativism. *Theory and Psychology, 10*, 481-502.

Rennie, D. L. (1999). Qualitative research: A matter of hermeneutics and the sociology of knowledge (pp. 3-13). In Kopala, M., & Suzuki, L. A., (Eds.), *Using qualitative methods in psychology*. Thousand Oaks, CA: Sage.

Rennie, D. L. (1998a). Grounded theory methodology: the pressing need for a coherent logic of justification. *Theory and Psychology, 8*, 101-119.

Rennie, D. L. (1998b). Reply to Corbin: From one interpreter to another. *Theory and Psychology, 8*, 129-135.

Rennie, D. L., Phillips, J. R., & Quartaro, G. K. (1988). Grounded theory: A promising approach to conceptualization in psychology. *Canadian Psychology, 29*, 139-150.

Repetti, R. L. (1990). Family and occupational roles and women's mental health. In M. Schwartz (Ed.), *Women at work - 1987*. Los Angeles: UCLA Institute of Industrial Relations.

Repetti, R. L., & Crosby, F. (1984). Women and depression: Exploring the adult role explanation. *Journal of Social and Clinical Psychology, 2*, 57-70.

Resick, P. A. (1983). Sex-role stereotypes and violence against women. In E. D. Rothblum & V. Franks (Eds.), *The stereotyping of women.* New York: Springer.

Rich, A. (1976). *Of woman born: Motherhood as experience and institution.* New York: Norton.

Rieker, P. P., & Jankowski, M. K. (1995). Sexism and women's psychological status. In C. V. Willie, P. P. Rieker, B. M. Kramer, & B. S. Brown (Eds.), *Mental health, racism and sexism.* Pittsburgh, PA: Pittsburgh University Press.

Roberts, R. E., & O'Keefe, S. J. (1981). Sex differences in depression reexamined. *Journal of Health and Social Behavior, 22,* 394-400.

Rounsaville, B. J. (1978). Theories in marital violence: Evidence from a study of battered women. *Victimology, 3,* 11-31.

Russell, D. E. H. , & Howell, N. (1983). The prevalence of rape in the United States revisited. *Journal of Women in Culture and Society, 8,* 688-695.

Russo, N. F., & Denmark, F. L. (1984). Women, psychology, and public policy: Selected issues. *American Psychologist, 39,* 1161-1165.

Sender, K. (1992). Lesbians, therapy, and politics: inclusion and diversity. *Feminism & Psychology, 2,* 255-276.

Shields, S. A. (1975). Functionalism, Darwinism, and the psychology of women: A study in social myth. *American Psychologist, 30,* 739-754.

Sipe, R. (1982). Political analysis and therapy. *Issues in Radical Therapy, 10,* 24-27, 54-59.

Sloan, T. Theories of personality: Ideologies and beyond. In D. Fox and I. Prilleltensky (Eds.), *Critical psychology: An introduction.* (pp. 87-103). Thousand Oaks, CA: Sage.

Smith, J. A. (1996). Semi-structured interviewing and qualitative analysis. In J. A. Smith, R. Harre, & L. Van Langenhove (Eds.), *Rethinking methods in psychology*. (pp. 9-26). Thousand Oaks, CA: Sage.

Sorenson, S. B., Stein, J. A., Siegel, J. M., Golding, J. M., & Burnam, M. A. (1987). The prevalence of adult sexual assault: The Los Angeles epidemiological catchment area project. *American Journal of Epidemiology, 126*, 1154-1164.

Sorisio, C. (1997). A tale of two feminisms: Power and victimization in contemporary feminist debate. In L. Heywood & J. Drake (Eds.), *Third wave agenda: being feminist, doing feminism*. (pp. 134-149). Minneapolis: University of Minnesota Press.

Stark, E., Flitcraft, A., & Frazier, W. (1979). Medicine and patriarchal violence: The social construction of a "private" event. *International Journal of Health Services, 9*, 461-493.

Statistics Canada. (1993). Earnings of men and women. In *The Daily*, January 14th, p.3.

Statistics Canada. (1991). 1991 Census: highlights. In *The Daily*, April 13th, p.1.

Steele, E., Mitchell, J., Greywolf, E., Belle, D., Chang, W., & Schuller, R. B. (1982). The human cost of discrimination. In D. Belle (Ed.), *Lives in stress: Women and depression*. London: Sage.

Steil, J. M. (1994). Supermoms and second shifts: Marital inequalities in the 90's. In J. Freeman (Ed.), *Women: A feminist perspective (5th Ed.)* (pp. 149-161). Mountain View, CA: Mayfield.

Steil, J. M., & Turetsky, B. A. (1987). Marital influence levels and symptomatology among wives. In F. Crosby (Ed.), *Spouse, parent, worker: On gender and multiple roles*. (pp. 74-90). New Haven, CT: Yale University Press.

Straus, M. (1993). Physical assaults by wives: A major social problem. In R. J. Gelles and D. R. Loseke (Eds.), *Current controversies on family violence*. (pp.67-87). Newbury Park, CA: Sage.

Straus, M., & Gelles, R. J. (1990). *Physical violence in American families: Risk factors and adaptations to violence in 8, 145 families*. New Brunswick, NJ: Transaction.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.

Strauss, A., & Corbin, J. (1994). Grounded theory methodology: An overview. in N. K. Denzin & Y. S. Lincoln (Eds.), *The handbook of qualitative research* (pp.273-285). Thousand Oaks, CA: Sage

Sullivan, E. (1984). *Critical psychology: Interpretation of the personal world.* New York: Plenum.

Tallen, B. S. (1990). Co-dependency: A feminist critique. *Sojourner, 15*, 20.

Tavris, C. (1992). *The mismeasure of woman.* New York: Simon and Shuster.

Terry, L. L. (1993). Revising feminist-informed strategic/systemic therapy. *Journal of Systemic Therapies, 12*, 89-91.

Tomes, N. (1992). Historical Perspectives on women and mental illness. In R. D. Apple (Ed.), *Women, health, and medicine in america* (pp. 143-171). New Brunswick, NJ: Rutgers.

Turk, J. L., & Bell, N. W. (1972). Measuring power in families. *Journal of Marriage and the Family, 34*, 215-223.

Twaddle, I. K. B. (1994). *Clinical psychologists' endorsement of mental disorder ideology as a function of personal sociopolitical values*. Unpublished doctoral dissertation, University of Windsor, Windsor, Ontario, Canada.

Unger, R., & Crawford, M. (1996). *Women and gender: A feminist psychology (2nd Ed.).* New York: McGraw-Hill.

Ussher, J. M. (1991). *Women's madness: Misogyny or mental illness?* Hemel Hempstead: Harvester Wheatsheaf.

Ussher, J. M. (1990). Clinical psychology and sexual equality: A contradiction in terms. *Feminism and Psychology*, 63-68.

Vanfossen, B. E. (1981). Sex differences in the mental health effects of spouse support and equality. *Journal of Health and Social Behavior, 22*, 130-143.

van Wormer, K. (1989). Co-dependency: Implications for women and therapy. *Women & Therapy, 8*, 51-63.

Vanek, J. (1984). Housewives as workers. In P. Voydanoff (Ed.), *Work and family: Changing roles of men and women.* (pp. 89-103). Palo Alto, CA: Mayfield.

Wallston, B.S., & O'Leary, V.E. (1981). Sex makes a difference: Differential perceptions of women and men. In L. Wheeler (Ed.), *Review of personality and social psychology.* (pp.9 -41). Beverly Hills, CA: Sage.

Walters, M. (1990). Feminist family therapy. In M. Pravder-Mirkin (Ed.), *The political and social contexts of family therapy.* Toronto: Allyn & Bacon.

Walters, M., Carter, B., Papp, P., & Silverstein, S. (1990). *The invisible web: Gender patterns in family relationships.* New York: Guilford.

Walker, L. (1993). The battered woman syndrome is a psychological consequence of abuse. In R. J. Gelles & D. R. Loseke (Eds.), *Current controversies on family violence.* (pp. 133-153). Newbury Park, CA: Sage.

Waterhouse, R. L. (1993). "Wild women don't have the blues": A feminist critique of "person-centered counseling and therapy. *Feminism & Psychology, 3*, 55-70.

Weisstein, N. (1968). *Kinder, kuche, kirche as scientific law: Psychology constructs the female.* Boston: New England Free Press.

Wenegrat, B. (1995). *Illness and power: Women's mental disorders and the battle between the sexes.* New York: New York University Press.

Westkott, M. (1989). Female relationality and the idealized self. *American Journal of Psychoanalysis, 49*, 239-250.

Westkott, M. (1990). On the new psychology of women: a cautionary view. *Feminist Issues.*

Widiger, T. A., & Settle, S. A. (1987). Broverman et al. revisited: An artifactual sex bias? *Journal of Personality and Social Psychology, 53*, 463-469.

Wirtz, P. W., & Harrell, A. V. (1987). Effects of postassault exposure to attack-similar stimuli on long-term recovery of victims. *Journal of Consulting and Clinical Psychology, 55*, 10-16.

Wolfe, J. (1995). Rational emotive behavior therapy women's groups: A twenty-year retrospective. *Journal of rational emotive and cognitive behavioral therapy, 13*, 153-170.

Wolfe, J. (1985). Women. In A. Ellis & M. E. Bernard (Eds.), *Clinical applications of rational emotive therapy.* (pp. 101-127). New York: Plenum.

Wolfe, N. (1994). *Fire with fire: The new female power and how to use it.* New York: Vintage.

Worell, J. & Remer, P. (1992). *Feminist perspectives in therapy: An empowerment model for women.* (pp. 112-142). New York: Wiley.

Zappert, L. T., & Stansbury, K. (1984). *In the pipeline: A comparative analysis of men and women in graduate programs in science, engineering, and medicine at Stanford University (Working Paper No. 20).* Institute for research on women and gender, Stanford, CA: Stanford University.

# APPENDIX A: INTERVIEW RECRUITMENT STATEMENT

## A PARTICIPATORY STUDY OF CLINICAL PSYCHOLOGISTS' VIEWS ABOUT APPROACHES TO THERAPY WITH WOMEN

Dissertation Research

Researcher: Heather A. Getty, M.A.

Research Supervisor: Charlene Y. Senn, Ph.D.

Women make up the majority of adults seeking outpatient psychological services, and outnumber men in diagnoses such as depression and anxiety disorders. Questions exist about the causes of women's mental disorders and how psychotherapy can best help women. The present study attempts to explore the range of explanatory models which clinicians find useful in understanding women's psychological distress. In addition, the study aims to explore how clinicians' views about the causes of women's distress influences their approach to assessment and therapy with female clients.

Rarely have psychologists been directly invited to offer their views, based on their own experiences, about these complex issues. As individuals working with women in complex situations, however, such information is crucial to improving theory and practice in the area of women's mental health. To provide this valuable information, I am asking clinical psychologists to offer their views and experiences about working with women in a semistructured interview. The interview should take approximately one hour to ninety minutes. As the goal of the study is to present a wide range of perspectives, all opinions will be considered valuable. You will be encouraged to discuss the issues that you feel are most important, or to digress from any question as you see fit.

Benefits of participating in this unique study include the opportunity to contribute to a new and important field of research, and to further one's own professional growth by reflecting on issues that have broad implications.

All responses will be held in strict confidence. After the study is completed, I will provide a summary of the perspectives which emerged during the interviews to those who request it.

Thank you very much for considering this request. I will contact you by telephone shortly to further determine your interest in participating in this research. If you would be interested in participating or need any additional information, please leave a message for me (Heather Getty, M.A.) at the Dept. of Psychology, University of Windsor, at (519) 253-4232, ext. 2217 or getty1@uwindsor.ca. I can make arrangements to meet with you at your convenience, even if you live outside the Windsor area.

## APPENDIX B: PARTICIPANT INFORMATION/CONSENT FORM

## A PARTICIPATORY STUDY OF CLINICAL PSYCHOLOGISTS' VIEWS ABOUT APPROACHES TO THERAPY WITH WOMEN

Dissertation Research
Researcher: Heather A. Getty, M.A.
Chairperson: Charlene Y. Senn, Ph.D.

We invite you to participate in a research study investigating clinicians' views about the causes and treatment of women's psychological distress. The purpose of the study is to explore the range of explanatory models which clinicians find useful in understanding women's psychological distress. In addition, the study aims to explore how clinicians' views influence their approach to assessment and therapy with female clients.

If you decide to participate in the study, your participation will involve an interview in which you will be asked to describe the models you have found useful in understanding women's distress, and your experiences of working clinically with women. As the goal of the study is to present a wide range of perspectives, you will be encouraged to discuss the issues that you feel are most important, or to digress from any question as you see fit. Interviews will be audiotaped for transcription and subsequently erased. The transcribed responses will be coded and kept strictly confidential. When this study is completed you will be able to obtain, on request, a summary of the results from the primary researcher (Heather Getty, M.A., Dept. of Psychology, University of Windsor, N9B 3P4).

This study has been cleared by the Ethics Committee, Dept. of Psychology, University of Windsor. Any concerns or questions about this research may be directed to the primary researcher noted above, to Dr. Charlene Senn, Ph.D., Dept. of Psychology, or to Dr. Stewart Page, Chair, Ethics Committee, Dept. of Psychology, University of Windsor, N9B 3P4 (519) 253-3000.

Please read to Recruitment and Information sheets, and, if you agree to participate, please sign below.

I understand that my participation is voluntary and that I may withdraw from the study at any time without penalty.

I also understand that my identity will be kept confidential. My name will never be used in connection with the study, nor in any reports of its results, now or at any time in the future. I agree, however, to allow my responses to be used on an anonymous basis in any publications based on the results. I understand that excerpts of my responses may be used verbatim, but that the source of these excerpts will remain strictly anonymous.

I have read both the recruitment statement and the participant information forms. I understand the description of the study and agree to participate in research procedures as described. I have also been given an opportunity to indicate any changes, limitations, or restrictions with this statement.

Name:_____

Date:_____

Signature:_____

# APPENDIX C: INTERVIEW SCHEDULE

## Interview Questions

### Concrete Cases of Therapy with Women

1. Can you describe a recent case of therapy with a female client? (Possible prompts: What were the presenting issues, what model did you find helpful in understanding her problems, and how did you intervene? What worked, and what might you have done differently?)

2. Could you describe a case that went well? That was unsatisfactory? (Possible prompts: What were the presenting issues, what model did you find helpful in understanding her problems, and how did you intervene? What worked, and what might you have done differently?)

### Abstract Constructions of Therapy With Women

3. What psychological models (other than the ones you've described already) do you tend to rely on when trying to make sense of a client's problems?

4. What models are useful to you in helping clients to work through their problems?

5a. Do there seem to be any problems or issues which are common to, or more prevalent amongst, your female clients?

5b. How do you understand these problems?

5c. How do you work with these issues?

6. Do you think that your approach to therapy is the same or different for female clients as opposed to male clients?

### Questions Which Are More Focused on the Utility of Feminist/Sociopolitical Models

7. Do you feel that women's position or role in our society has any influence on the problems they bring to therapy? (Possible prompts: Can you tell me more about it? How so? If not, why not?)

7a. How do your views about this affect the way you do therapy with women?

8. Some psychologists feel that theories of women's distress should take into account their frequently lesser social power relative to men, and the problems that result from that state of affairs. Is this type of an analysis ever useful to you in your work with women? (Prompt:

How so? Can you tell me more about it?)

9. How would you say that your views about this affect the way you do therapy?

10. Are you familiar with feminist forms of therapy? What is your understanding and evaluation of them?

11. How similar or dissimilar are your views and practices from feminist forms of therapy, as you understand them?

12. (If the individual has described endorsing a sociopolitical analysis) Describe a case where a sociopolitical view was helpful, and where it was not helpful. How do you understand this?

## Additional Questions Suggested by Participants

-Can you tell me about a female client for whom issues of gender and power seemed (or, did not seem) particularly salient? How did you conceptualize what was going on and intervene?

-How would you characterize women's status or level of power in society?

-How central are issues of gender and power to your work?

-Did you feel compelled to talk a certain line in the interview today?

-How was it for you to take part in the interview today?

-Do you have any questions for me?

(Plus additional probes for issues which emerged as important themes in the interviews, such as the role of values in therapy and the concept of victimhood.)

# APPENDIX D: OVERVIEW OF GROUNDED THEORY METHODOLOGY

Grounded theory methodology is a systematic method which allows researchers to derive conceptual theories that explain how basic problem or social processes are continually addressed by participants. Grounded theory was originally developed by B. Glaser and A. Strauss (1967) in an effort to develop methods of theory development which were grounded in the daily experiences of social actors, rather than by rational empiricist methods common in sociology at the time. Grounded theory's emphasis on the researcher getting in the field to see what is going on, the importance of theory grounded in participants' realities, and the nature of experience as complex and continually evolving, and the active role of persons in shaping their worlds through a process of symbolic interaction stemmed from the work of theorists such as John Dewey, George Herbert Mead, Herbert Blumer, Robert K. Merton, and others (Glaser, 1978, 1996; Rennie, 1998).

The processes of constant comparison, memoing, and theoretical sampling are central to the creation of grounded theory. In grounded theory, interview data are broken down into meaning units that reflect discrete phenomena which include, but are not limited to, such things as participant activities, incidents occurring in the field, or participant viewpoints occurring within an area of interest. These meaning units are then labeled according to the concepts they may represent. The method of constant comparison is used to develop concepts, categories (more abstract, complex classifications of concrete concepts, often characterized by dimensions or properties), and complex, integrated theory (where many complex categories are interrelated into processual or other organizing schemes that work and fit in light of the data). Two analytic procedures are basic to the constant comparative method of developing codes, categories, and integrated theory. The first pertains to the making of constant comparisons of meaning units in the data to other meaning units, and then when codes emerge, incident to code. The second is the asking of the neutral coding questions: "What is this data a study of?" "What category or property of what category does this incident indicate?" "What is actually happening in the data?", and lastly, "What is the basic social psychological process or social structural process that processes the main problem that makes life viable in the action scene?" In developing categories and theory, the researcher looks for patterns in the data so that a pattern of many similar concepts can be named as a category, and dissimilar incidents can be named as a property of the category, or, if sufficiently dissimilar, a separate category entirely.

As analysis by constant comparison proceeds, attention focuses more selectively on elaborating the characteristics of the certain categories which define main problems within the area of interest and the ways in which they are handled by individuals. Concepts and categories are retained when they relate to other categories and make a difference how the main problem is handled. As the goal of grounded theory is not exhaustive conceptual description, emphasis is placed on how categories meaningfully relate to resolving the main problems within the area of interest. As a result, some instances and distinctions inherent in some categories may be collapsed as analysis proceeds. The development of grounded theory is also aided by the researcher's creation of theoretical memos. Memoing allows the researcher to capture his or her iterative ideas about the nature of concepts and categories, and the relationship between categories in solving the main problem in a topic area. At some point, the researcher learns that compared incidents in the data can be seen as interchangeable indices for the same concept or category. The existence of many interchangeable incidents is called saturation. When saturation is achieved, it is

unnecessary to keep collecting more incidents which keep indicating the same patterns and offer no new properties. The process of constant comparison, when used carefully and with attention to the researcher's preconceptions and impact on the data, allows the most important information pertaining to subjects' management of the central problem to emerge and be incorporated in a grounded theory.

In contrast to much quantitative research, which aims to make statements about the average member of a population on the basis of statistics derived from random samples, the focus in grounded theory is developing thick descriptions of the central problem within an area of interest, and is based on a process of theoretical sampling (Glaser, 1978). In theoretical sampling, data collection and analysis proceed together and the codes, categories, and overall picture that develops yields suggestions about where the researcher can try to find new and different perspectives to elaborate the picture that is emerging. In short, theoretical sampling in grounded theory is the process by which data collection is continually guided. Deduction in grounded theory is used minimally and closely in order to derive, from emergent codes, conceptual guides as to where to go next. Groups are chosen as they are needed rather than before the research begins, and apparent noncomparability of groups is not an issue, as the comparisons are based on concepts, categories, or properties appearing in both groups. The general procedure of theoretical sampling is to elicit codes from raw data from the start of data collection through constant comparative analysis as the data is gathered. Then one uses the extant concepts to guide further data collection, from which the concepts are further developed theoretically with properties and connections with other categories until each category is saturated. Theoretical sampling on any category ceases when it is saturated, elaborated, and integrated into the emerging theory (Glaser, 1996).

# VITA AUCTORIS

Heather Getty was born in Chatham, Ontario. She graduated from John McGregor Secondary School in 1990. She earned a B.A. (Hons.)and Board of Governors Medal in Psychology from the University of Windsor in 1994. She earned her M.A. in Psychology at the University of Windsor in 1996, and hopes to graduate from the University of Windsor with a Ph.D. in Psychology in October, 2002.